INDEPENDENT REVIEW OF REPORTING PROCEDURES IN CHILDRENS' RESIDENTIAL CARE FACILITIES

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An undertaking such as this Review is dependent on the involvement and assistance of many people. I am grateful to the hundreds of individuals with whom I had an opportunity to meet or speak over the course of the Review. Their knowledge and experience was an important resource.

My sincere thanks to Jay Rodgers and Paul Vincent who provided invaluable assistance in every aspect of the Review.

Most of all, I wish to express my gratitude to the many children with whom I had opportunity to meet. Their collective voice was clear and insightful and of enormous assistance. Their courage and their stories will remain with me for many years.

EXECUTIVE SUMMARY

The Independent Review into Child Abuse Reporting Procedures in Children's Residential Care Facilities was established in August 1991. The Terms of Reference for the review cover five main areas: An examination of legislation, regulations and standards; The application of reporting requirements by facilities; Procedures for ensuring facilities at all levels are aware of requirements; Procedures for ensuring adherence to requirements; and, Personnel practices including screening, training, and supervision. The Review was not incident-specific, but systemic in nature.

The Review was established as a result of recommendations arising from a review at Knowles Centre conducted in June of 1991. Anomalies and inconsistencies in reporting procedures and practices were revealed. Concern arose that similar situations may exist elsewhere in the system. The purpose of the Review was to investigate the adequacy of existing guidelines and practices, and make recommendations to improve the handling of child abuse allegations as they relate to child care institutions, youth centres and other child care facilities.

The Review Team met with many individuals, groups, and organizations including current and former residents of

the system. Those interviewed provided keen insight into the day to day operations of the children's residential care system. The testimony of children was compelling and of enormous value. The Review Team was impressed with the level of dedication and effort put forth by many working in residential care facilities who are asked to perform very important work with difficult children under very trying circumstances.

Deficiencies at all levels were found. The Report makes recommendations in a variety of areas. The Child and Family Services Act must be strengthened and clarified. It also must be enforced. Standards and regulations must be made consistent with the Act, be administered by one authority, and be enforced. Regular monitoring and review of facilities also has to occur.

There is a need for better training, recognition and support for those who work in residential care facilities. A classification and licencing system for youth care workers similar to that in the Child Day Care system should be a priority.

Some balance must be brought to the process of investigating allegations or suspicions of child abuse. A central team of investigators should be established to con-

duct investigations in residential care facilities to ensure consistency and quality in the process.

The proposed Children's Advocate is an important and greatly needed safeguard for children in care, and should be independent of the child welfare system, in a similar fashion to the Ombudsman.

Placement resources for children are often inadequate and must be improved. It is essential that the system address the needs of Aboriginal children in care.

It was not the intent of this Review to single out any particular component for special attention. Enough concerns were raised by those interviewed, however, to make it impossible to avoid certain issues.

The recommendations made in this report should be viewed as a package. It is essential that any response recognize this fact and change occur in a planned and co-ordinated manner.

Residential care facilities are part of a larger complex service system. Many of the issues in residential care are symptoms of deep-rooted and longstanding problems in the larger system. If the system truly values children, it is imperative that these fundamental problems be addressed.

For this to happen, those involved at all levels of the system must take responsibility and work together to find solutions.

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CHAPTER I

CHAPTER I - INTRODUCTION AND BACKGROUND

The Independent Review into Child Abuse Reporting Procedures in Children's Residential Care Facilities was announced on August 7th, 1991 by the Minister of Family Services, the Honourable Harold Gilleshammer.

The Review arose as a result of an incident-specific review conducted at Knowles Centre, Inc. in June 1991. The review at Knowles Centre came about because of the late reporting of allegations by former residents of Knowles Centre that while they were in care, they had been abused by Knowles' staff. The incidents allegedly occurred between 1983 and 1985. The disclosures were made between November 1989 and February 1990. Knowles Centre did not report to authorities until March 1991, more than a full year after the disclosures were first received.

The Knowles Review found that line staff had followed the Centre's policy for reporting alleged child abuse. This policy was not consistent with the reporting requirements under The Child and Family Services Act (the Act). During the Review several other incidents, some dating back to 1982, were discovered that either were not reported or

reported in a manner that was inconsistent with the requirements of the Act.

These findings raised many questions about the safety of children in Manitoba's residential care system. Were the irregularities found at Knowles Centre unique to that facility, or prevalent across the entire children's residential care system? Was the non-reporting intentional, due to ignorance of the legal provisions or could it be attributed to a lack of communication between management and staff? Given the time lapse between the alleged abuse, the disclosures and the reporting, why had this not been detected through regular monitoring of the facility? Finally, what safeguards are in place to prevent abusers from working with children in a residential setting?

Due to the concerns presented by these unanswered questions, the Knowles Review made the following recommendation:

> "In view of the volume of incidents which came to the attention of the Review Team, the Department of Family Services review the application of Child Abuse Reporting Procedures in other residential care facilities in Manitoba."

In response, this Review was established as a committee of the Minister of Justice and Attorney General pursuant to Section 4 of The Attorney General's Act. The purpose of the Review is to investigate the adequacy of existing guidelines and practices and make recommendations to improve the handling of child abuse allegations as they relate to children's residential care facilities.

P. Colleen Suche, a Winnipeg lawyer, was appointed to conduct the review. Two staff from the Policy and Planning Branch of the Department of Family Services were seconded to assist in the completion of the Review.

A. TERMS OF REFERENCE FOR THE REVIEW

The terms of reference for this review are contained in the Order-In-Council creating the committee which states that the purpose of the review is:

> " to conduct a thorough review of the policies and procedures followed by child care institutions, centres for young offenders and other residential care facilities for children in Manitoba as deemed necessary in the reporting of suspected or alleged child abuse to the appropriate child caring agency or local police force."

The term "child care institutions" is interpreted to mean the four residential treatment centres for children

in care in Manitoba (Knowles Centre, McDonald Youth Services, Children's Home of Winnipeg, and Marymound Inc.) and "centres for young offenders", the Manitoba Youth Centre in Winnipeg and the Agassiz Centre for Youth in Portage la Prairie.

The phrase "other residential care facilities for children in Manitoba as deemed necessary" is interpreted to include:

- licensed group homes providing emergency or long term residential care for abused or neglected children;
- licensed group homes and large centres providing residential care for disabled children, or children with a chemical dependency;
- Seven Oaks Youth Centre.

Whenever the term "children's residential care facility" is used in this report it is intended to cover the range of facilities listed above, although distinctions are sometimes made between the residential care component and youth corrections component. Foster care and open custody homes established pursuant to the Young Offenders Act are not part of this review.

The terms of reference spelled out five key areas to be examined. They are:

(a) the adequacy and appropriateness of current legislative requirements, regulations and standards and of care facilities' internal policies and procedures for reporting suspected or alleged child abuse to appropriate authorities;

(b) the manner in which care facilities' staff, management, and board members have applied established reporting policies and procedures when suspicions or allegations of child abuse have been raised;

(c) procedures for ensuring that all staff, management, board members and children in residential care facilities are familiar with and understand reporting requirements and protocols;

(d) procedures for ensuring adherence to reporting requirements; and

(e) personnel practices, including screening procedures for new employees, staff training in reporting procedures, and the assignment or supervision of staff suspected or alleged to have committed child abuse.

This is not an incident-specific review. Where appropriate, specific incidents may be referred to as a means of highlighting issues or pointing to particular concerns which cannot be presented in any other manner.

B. REVIEW PROCESS

The information gathering process involved the following:

1. **Analysis of Legislation**

A key objective for this Review is to assess the legal reporting requirements contained in The Child and Family Services Act. This involved an analysis of whether the legislated reporting requirements are appropriate, whether there are adequate sanctions for those who breach the Act, and a comparison with legislation in other provinces.

2. **Interviews With Officials in Other Provinces**

Telephone interviews were conducted with senior child welfare and youth justice officials in other provinces. These interviews allowed the Review Team to gain a national perspective on services for children and proved to be a source of valuable data.

3. **Survey of Children's Residential Care Facilities**

A questionnaire was sent to the four treatment centres, a sample of group homes, and to the two youth correctional facilities.

Approximately 95% of the questionnaires were completed and returned. Overall, the quality of responses was very high and the data gleaned from the process essential to many of the conclusions herein.

4. **Interviews**

Interviews with a great many individuals and groups involved in child welfare and youth justice were conducted. This included line, supervisory and management personnel from facilities and Child and Family Service agencies (referred to in this report as "agencies"), employees in the Child and Family Support Directorate (referred to in this report as "the Directorate"), law enforcement and other agencies, interest groups and individuals. An open-ended approach was used to allow for a large amount of information to be collected without jeopardizing the objectivity of the process.

5. **Literature Review**

Studies and journal articles related to child abuse and safety for children in residential care were reviewed (see selected bibliography).

6. **Review of Incident Reports**

A sample of incident reports filed at the Directorate and incident reports kept on file at a number of residential care facilities were examined. This provided information on the quality of the reports, and the appropriateness of responses by Directorate and agency workers.

The knowledge and experiences of people working in and close to the residential care system was an important

component in this review. These individuals best know the issues and problems and what solutions may be most effective.

The true experts in this field are the children who have been in residential care in Manitoba. A number of children currently living in a residence as well as children who previously lived in a residential setting were also interviewed. The compelling testimony by these children about their experiences in residential care brought unequalled insight into a system that is intended to ensure their safety.

C. EXAMINATION OF THE CHILD DAY CARE SYSTEM

Manitoba's day care system is one of the finest in the country and contains a highly structured system of accountability. A number of the key issues in child day care are similar to those in residential care, and for this reason many comparisons are useful.

D. MATERIALS PROVIDED BY THE CHILD AND FAMILY SUPPORT DIRECTORATE AND RESIDENTIAL CARE FACILITIES

The Child and Family Support Directorate provided a variety of documents to assist in the review process. Budgets, funding submissions, policy papers, program descriptions, standards manual, as well as special reports done by the Directorate on specific incidents or cases were reviewed.

Some facilities provided internal documents such as personnel policies, procedure manuals and annual reports.

CHAPTER II

CHAPTER II - CHILDREN'S RESIDENTIAL CARE AND YOUNG OFFENDERS FACILITIES IN MANITOBA

Residential care facilities consist of group homes, treatment centres, Seven Oaks Youth Centre, specialized resources, and young offenders' facilities (youth centres). In total, the residential facilities covered by this review provide spaces for more than 700 children and employ over 500 staff. There are 175 spaces in group homes, 179 in treatment centres, 32 spaces at Seven Oaks and more than 200 spaces in special resources. In addition, the Department of Justice through its Community and Youth Corrections Division provides 230 beds in its youth centres. The resources available in the residential care system for the placement of children are described in the following pages.

The Child and Family Services Act contains the following definitions:

> "group home" means a home for not less than four and no more than eight children placed by an agency for full time care and supervision;
>
> "treatment center" means any place established or designated primarily for the care and treatment of more than eight children and includes facilities operated by any government department for those purposes, but does not include facilities for the reception and temporary detention of a child;

> "**place of safety**" means any place used for the emergency temporary care of a child as may be required under this Act and includes treatment centres;

And, under The Young Offenders Act (YOA), youth centres fall within the following definitions:

> "**open custody**" means custody in
>
> (a) a community residential centre, group home, child care institution, or forest or wilderness camp, or
>
> (b) any other like place or facility
>
> "**secure custody**" means custody in a place or facility designated by the Lieutenant Governor in Council of a province for the secure containment or restraint of young persons, and includes a place or facility within a class of such places or facilities so designated.

With a few exceptions, facilities falling within the child and family services system are classified according to level of care. The levelling system is set out in the Child and Family Services Standards Manual. The "levels" and associated criteria are intended to match children with similar needs and with appropriate resources.

Briefly, the levelling system can be described as follows:

Level II - Clients: situational problems, minor behavioral, emotional, or interpersonal problems; Program: "family routine" directed towards living in a family, may be mild retardation.

Level III - Clients: moderate behavioral, emotional, interpersonal, some situational problems. The distinction from Level II children is one of degree of severity of the presenting issues which requires more intensive tolerance, understanding, and supervision than can be reasonably handled in a family setting; Program: "activity program" directed toward socialization. There is more structure, perhaps group work, more coordinated activities, for "therapeutic" reasons.

Level IV - Clients: volatile children with high degrees of behavioral, emotional, interpersonal problems, e.g., very poor/low coping abilities, many crises, often resistant to intervention, a high risk to themselves or others; Program: planned individualized program directed towards increasing awareness and self-control. More intensity in the coordination of the child's time and assistance with using and accessing other resources for personal and therapeutic reasons.

Level V - Clients: severe emotional disturbance, psychiatric problems, violence, severe retardation. These children are frequently a danger to self/others, unable to handle demands of daily living/school, and require detailed individualized treatment plans and considerable control/structure; Program: therapeutic directed towards interpersonal and emotional growth. Focus is on building personal abilities around insight/understanding of self/behaviors and effect on others, assisting in effecting behaviour change, improving self-skills.

Except for Seven Oaks Youth Centre, some specialized resources, and the youth centres, facilities are designated for levels of care from II to V. The following description of resources is grouped by type of resource and then by the level of care. Where exceptions exist these are noted.

A. GROUP HOMES

There are twenty-one group homes in the Province. There are ten in Winnipeg, four in Western Manitoba, one in Eastern Manitoba, three in Central Manitoba and three are located in Northern Manitoba.

1. **Level II**

Three facilities are classified as level II resources with a capacity for 24 children and employing over 25 staff.

2. **Level III**

Thirteen facilities are classified as level III group homes with a capacity for 111 children employing over 97 staff. The group home operated by Churchill Health Centre is also designated as an emergency receiving resource.

3. **Level IV**

Four facilities are classified as level IV group homes with a capacity for 32 children employing over 40 staff. One operated by Marymound, Inc. in Thompson, is also designated as an emergency receiving resource.

4. **Level V**

One group home is designated as a level V resource with a capacity for 4 children employing approximately 8 staff.

In summary, there are 21 group homes (including emergency receiving group homes) in Manitoba with a capacity for 175 children.

B. TREATMENT CENTRES

There are four privately operated treatment centres plus Seven Oaks Centre for Youth. All are located in Winnipeg. Under the auspices of the four centres there are four Level III resources comprising 30 beds, nine Level IV resources comprising 108 beds, and one Level V resource of 4 beds. Seven Oaks is an emergency placement resource operated by the Province with a capacity of 32 beds. Over 300 staff are employed to run these resources and deliver the programs.

Treatment centres include The Children's Home of Winnipeg, Knowles Centre Inc., MacDonald Youth Services, and Marymound, Inc. Treatment centres are different from group homes in that they provide clinical services as part of a child's treatment plan and offer programs and services to children and families in the community.

1. Children's Home of Winnipeg

Children's Home of Winnipeg is a non-profit agency run by an independent board which operates three group home settings for children assessed at Level IV with a capacity for 24 male children.

Twenty-one beds are designated for Provincial referrals. A further three beds are designated for other

sources of referrals. Children's Home also operates a separate 5 bed home for very high needs children and adults.

Children's Home provides services through a number of programs to aid disadvantaged children and youth and adolescent females in becoming independent and fully functional adults; to assist and support families and parents; and to provide services for the multi-handicapped.

2. Knowles Centre Inc.

Knowles Centre is a non-profit agency run by an independent board which operates a level IV facility. It provides long term care for children and families who require intensive intervention.

There are three units located within its campus setting with a total capacity for thirty-two males and females aged 12-16. Twenty-four of the beds are designated for Provincial referrals and the remainder are for other sources of referrals. Sixteen spaces are for males and sixteen for females. The facility has locked settings in two units housing eleven males/females.

To carry out its programs Knowles employs a total of forty-two staff.

3. **MacDonald Youth Services** (MYS)

MYS operates four group homes designated as level IV facilities with a capacity for 32 males ages 12-17. MYS also operates a four bed level V long term care/treatment group home for males aged 13-17 who have committed a sexual offence.

MYS, like Knowles and Children's Home, provides other programs and services in support of their residential programming. These include support for children in their care and their families, families in need in the community, workforce training, alternative parent homes, and a sexual abuse victims group.

MYS employs 52 full-time staff and 61 part-time staff in the delivery of its residential and support programs. Programming is coordinated from a central location with clinical and therapy support as required.

4. **Marymound Inc.**

In addition to the Thompson receiving home, Marymound also provides long term residential care/treatment to

female children/youth on three floors at its main Winnipeg location on Scotia Street, which is a locked setting and designated as level IV. As well, Marymound operates four level III group homes in Winnipeg. Marymound facilities have a total capacity for sixty children/youth.

Marymound has two social workers on staff and psychological consultation is available as needed. In addition to the residential resources, Marymound provides support services such as the Family Support Program in The Pas and Winnipeg, an independent living program for adolescents, a day treatment program and sexual abuse offender program. Marymound employs over 70 staff in delivering its programs and services as well as a number of volunteers.

As an incorporated body Marymound has an eleven member corporate board in place. To provide advice and oversee its programs and services it also has in place a 21 member advisory board.

C. **SEVEN OAKS YOUTH CENTRE**

Seven Oaks Youth Centre is designated as a "place of safety" pursuant to the Act. It was built in 1960 as a

facility for female juvenile offenders, then known as the Manitoba Home for Girls. Male residents were introduced in 1976. In 1979, it ceased to operate as part of Youth Corrections and became a child welfare facility.

Unlike other emergency placement/receiving resources, Seven Oaks is operated by the Province, reporting to the Director of Child and Family Services (referred to throughout this report as the "Director"). It is the only locked receiving facility in Manitoba and provides emergency placement for up to 32 children aged 12-18. It is available to placing agencies across the Province based on a quota system. Three of the thirty-two beds are allotted for emergency placement purposes, seven are allotted for rural placing agencies, and the remaining twenty-two beds are for use by Winnipeg Child and Family Services.

The Seven Oaks facility is divided into two units. One unit is co-ed, the other is for girls. Seven Oaks employs 47 staff.

Originally intended to house in excess of 60 children, Seven Oaks has reduced its capacity on a number of occasions over the past decade (most recently following the

Reid/Sigurdson Report in 1987). Its current capacity of 32 is divided to provide 20 spaces for girls and 12 for boys.

D. SPECIALIZED RESOURCES

A number of residential care facilities are considered specialized resources. Generally, these facilities provide services to very specific clientele. The children either have a developmental disability or a chemical/substance dependency problem. Resources with a level designation, if any, will be described first followed by resources without a Level designation.

1. Level-Designated Special Resources

(a) Level II

St. Amant Centre operates two level II facilities in Winnipeg for twelve mentally disabled children aged 10-17. Staffing includes a full-time live-in housemother, one part-time housekeeper, one group coordinator and seven part-time counsellors for each facility.

Virden House Project Inc. is a six bed facility for mentally disabled males or females aged 12-21.

(b) Level III

Bannatyne/Glenwood Children's Homes is a twelve bed facility for male or female children aged 1-8 who are chronically ill or disabled. Staff includes a nurse supervisor and four live-in child care workers.

Green Pastures Retreat Inc. is a nine bed group home which accepts children who are solvent abusers aged 12-18. Twelve staff are employed to provide the program and services.

The Pas Children's Home Inc. is a six bed facility (plus one crisis bed) for males or female children aged 4-18 who, on admission, are diagnosed as having a mental disability.

(c) Level IV

Hydra House operates two six bed facilities in Winnipeg for males or females aged 8-17 with a mental disability or psychiatric disorder.

2. Special Resources (no Level designation)

St. Amant Centre also operates a total care in-

stitution for children and adults with mental and physical disabilities. There were 112 children and 135 adults in the Centre as of January 1992. The Centre employs the equivalent of 410 full time staff.

St. Norbert Foundation, located just outside Winnipeg, operates two twelve bed facilities for males and females aged 14 -17 with chemical dependency problems.

E. YOUNG OFFENDERS FACILITIES

1. The Manitoba Youth Centre (MYC)

MYC provides services for youth who have been taken into custody pursuant to The Young Offender's Act. MYC is divided into three centres: Kenaston (pre-trial detention), Willow (open custody) and Doncaster (secure custody). In total MYC is divided into ten cottages with fifteen bedrooms in each for a total capacity of one hundred and fifty. One hundred and forty-three staff are employed at MYC. At present there are twenty-four residents of MYC who are either temporary or permanent wards of the Director.

Each cottage has one supervisor, five juvenile counsellors, a special education teacher and several part-time staff.

MYC also provides a number of programs and services related to education, intervention, recreation, health, counselling and temporary absences.

2. Agassiz Youth Centre (Agassiz)

Agassiz is a "secure custody" facility for youth taken into custody pursuant to The Young Offender's Act. It is the main setting in Manitoba for youth male offenders age 14 - 20. It has a bed capacity of eighty and employs 83.1 staff.

Agassiz is divided into cottage-style living units intended for groups of eight to twelve youth. At present there are four units housing 105 youth of whom four are either temporary or permanent wards of the Director of Child and Family Services. Agassiz also operates Crescent Centre which is an open-custody setting.

Children's residential facilities are summarized in the table below.

Children's Residential/Young Offender's Facilities by Type/Level and Capacity

Type/Level	II/beds	III/beds	IV/beds	V/beds	Other
Group Homes	24	130*	24-28**	4	
Treatment+		30	112	4	
Seven Oaks					32
Specialized	18	19*	12		201
Young Offenders					230
Total	42	179	148-152	8	462

*includes one crisis bed; **includes 4 respite beds (one location can vary its capacity); + these figures include cottages, floors, units located either at the same location and/or operated by the same organization.

CHAPTER III

CHAPTER III - REPORTING OF ALLEGED OR SUSPECTED CHILD ABUSE: REQUIREMENTS OF THE CHILD AND FAMILY SERVICES ACT

All child welfare statutes in Canada require mandatory reporting when a person believes a child is in need of protection. This is intended to ensure that children who are at risk are identified promptly and reported to someone in a position to protect the child. To be effective, child protection legislation should clearly state those situations that must be reported. A prime objective of mandatory reporting is to put the assessment of degree of risk in the domain of the child welfare professional.

The legislation must have enforceable penalty provisions in order to be a deterrent for those who do not follow the reporting requirements. It is also important that any guidelines or protocols for reporting be consistent with the statute.

In Manitoba, while reporting a child in need of protection is mandatory, to whom the report is made may differ depending on the child's situation. Section 18(1) of The Child and Family Services Act provides:

> "....where a person has information that leads the person reasonably to believe that a child is or might be in need of protection as provided in section 17, the

> person shall forthwith report the information to an agency or to a parent or guardian of the child."

Section 18(1.1) specifies the situations where the information must be reported to an agency only: if the person does not know the identity of the parent/guardian; believes the parent/guardian to be responsible in some way for the child to be in need of protection; or believes the child is or might be suffering abuse.

A. CHILD ABUSE AND ILLUSTRATIONS OF A CHILD IN NEED OF PROTECTION

Child abuse is given special attention in s.18(1.1)(c). Where a person has reason to believe that a child is or might be suffering abuse, the information must be reported directly to an agency, regardless of whether the person views the parent or guardian as being responsible for the abuse.

Uncertainty arises when it comes to knowing exactly what has to be reported. This is a major issue for residential care. Although most residential care workers interviewed knew of the legal reporting requirements, there was much ambiguity regarding what had to be reported. Repeatedly, the Review Team was told that many incidents fit into a "grey area" where it is not clear whether reporting is man-

datory. This is often due to the fact that many staff are not clear on the meaning of a "child in need of protection", and tend to focus on the definition of "abuse".

Section 18(1) requires that a person report when he or she believes a child is, or may become in need of protection. Section 17(1) defines when a child is in need of protection:

> "For purposes of this Act, a child is in need of protection where the life, health or emotional well-being of the child is endangered by the act or omission of a person."

Section 17(2) contains a list of illustrations of when a child is in need of protection. This is not intended to be exhaustive but rather to provide guidance in interpreting section 17(1). The list should be as comprehensive as possible to reduce uncertainty about whether specific types of incidents are to be reported. Incorporating a more detailed list of illustrations into the Act may clarify the intent and meaning of section 17(1).

It is recommended that:

The Department of Family Services review section 17(2) of The Child and Family Services Act to determine if the list of illustrations of when a child is in need of protection should be expanded.

B. DEFINITION OF ABUSE

"Abuse" is defined in The Child and Family Services Act as follows:

> 'abuse' means an act or omission of a parent or guardian of a child or of a person having care, custody, control or charge of a child, where the act or omission results in
>
> (a) physical injury to the child,
>
> (b) emotional disability of a permanent nature in the child or is likely to result in such a disability, or
>
> (c) sexual exploitation of the child with or without the child's consent;

The reference to "omission" encompasses failure to protect and failure to supervise in addition to the act of committing abuse of a child. The definition of abuse is broader than some other jurisdictions where it is limited to an act or omission of a parent or guardian.

The definition emphasizes the result of an act or omission. For an incident to constitute physical abuse, the result of an act or omission has to be an injury to the child. This is similar to the approach used in Alberta and New Brunswick.

The use of the word "injury" when referring to physical abuse is somewhat narrower than definitions found in the Ontario and Nova Scotia Acts. Both statutes use the term "physical harm" instead of "physical injury" when defining a child in need of protection. "Harm" may create a broader base for establishing that a child is in need of protection, and should be considered as an alternative for existing wording.

It is recommended that:

Consideration be given to changing the definition of "physical abuse" in the Child and Family Services Act to use the term "physical harm" instead of "physical injury".

The definition of emotional abuse is problematic. Requiring that there be evidence or likelihood of a permanent disability is far too rigid a criterion to encourage reporting. Child protection statutes in other jurisdictions have a broader definition of emotional abuse. Alberta, for example, uses the term "emotionally injured" and emphasizes the existence of observable behaviors, such as anxiety, depression, withdrawal, aggression, or delayed development.

Nova Scotia and Ontario use the term "emotional harm" in their definitions, and also emphasize the existence of observable behaviors. Although not in the Alberta Act,

both Ontario and Nova Scotia specify that the child is not in need of protection unless the parent/guardian does not provide, refuses or is unavailable/unable to consent to services or treatment to alleviate the emotional harm. Nowhere, in any of these other statutes, is there reference to an emotional disability of a "permanent nature".

Many children in residential care have come from environments where they experienced extensive emotional abuse. These children are particularly vulnerable to emotional harm. If the system is serious about ensuring the safety of children, there must be mechanisms in place to ensure that emotional harm is reported.

It is recommended that:

The definition of emotional abuse in The Child and Family Services Act be replaced with a new definition which uses the phrase "emotional harm".

"Emotional harm" be defined further in the Act to include observable behaviors similar to the provisions in the Alberta, Nova Scotia and Ontario statutes.

C. REPORTING PAST ABUSE AND THIRD PARTY ASSAULT OF CHILD

Two issues arise from the wording of the illustrations in section 17(2). First, is the reporting of past abuse of a child. Section 17(2) states that a child is in need of protection where the child:

> "(c) is abused or is in danger of being abused;"

This wording focuses on present (is) and risk of potential abuse (in danger). The Manitoba Guidelines on Identifying and Reporting a Child In Need of Protection state that this section should be interpreted to include disclosures of past abuse. Point 6 of Part II of the Guidelines reads:

> "The phrase 'is abused' applies to the past as well as the present. Abuse that may have occurred in the past is reported to an agency where the person having this information reasonably believes the child is currently in need of protection."

Based on the Guidelines, a disclosure of past abuse could indicate a child is in need of protection and is subject to the mandatory reporting requirements. If this is the intent, it should be made more explicit in the Act. The guidelines are not enforceable and are somewhat misleading in that the child who has disclosed past abuse must be in need of protection before it is reportable. This does not address the situation where a disclosure of past abuse indicates that other children may be in need of protection, especially where the alleged victim is an adult.

Interviews conducted by the Review Team revealed widespread uncertainly about the reporting of past abuse. There will be situations where a disclosure of past abuse does indicate that a child is in need of protection, and should be subject to the mandatory reporting requirements. Again, it is important that through reporting, the assessment of risk be put in the hands of professionals.

Other child protection statutes include past abuse within the definition of a child in need of protection. For example, the Saskatchewan, Ontario and Nova Scotia Acts all use the term "has suffered" when referring to abuse or neglect. This wording incorporates past abuse within the mandatory reporting provisions of these statutes.

Although the reporting of past abuse is referred to in the Manitoba Guidelines, the legislation should be equally as definitive. This could be done by amending section 17(2)(c) to include past abuse within the illustrations of a child in need of protection, or by adding a separate section on reporting of past abuse.

It is recommended that:

The Child and Family Services Act be amended to include specific reference to past abuse within the mandatory reporting requirements.

The Guidelines be revised to be consistent with the Act.

The second issue is the reporting of third party assault of a child. Unlike abuse, the term "third party assault" is not defined in The Child and Family Services Act. Third party assault can result in a child being in need of protection. Section 17(2)(f) of the Act reads:

> "...a child is in need of protection where the child
>
> (f) is subjected to aggression or sexual harassment that endangers the life, health or emotional well-being of the child;"

Third party assault fits within this illustration and, as with past abuse, is subject to mandatory reporting. This is a point not well understood in the residential care system. The effects of a third party assault on a child can be just as serious as an act of abuse. The obligation to report third party assault should be clear. Nova Scotia, for example, has a specific section in The Children and Family Services Act which defines third party abuse and another section which requires mandatory reporting of any act or omission consistent with that definition.

It is recommended that:

The Child and Family Services Act be amended to include a specific definition of third party assault and the Act clearly state that third party assault is subject to the mandatory reporting provisions.

D. PENALTIES FOR FAILURE TO REPORT A CHILD IN NEED OF PROTECTION

The Act provides two types of sanctions for violating the mandatory reporting requirements. Under section 18.3, anyone who fails to report commits an offence punishable on summary conviction. Under section 18.2(1) the Director may report a person who fails to report information to the professional society or association or regulatory organization of which the person is a member or that governs the professional status of the person. Section 18.2(2) requires the society, association or regulatory organization to investigate.

The Act designates failure to report as a summary conviction offence, but does not prescribe specific penalties or limitation periods for prosecutions under the Act. In the absence of such stipulations, the penalties in The Summary Convictions Act apply. These are a maximum fine of $500.00, six months in prison, or both. Pursuant to section 786(2) of the Criminal Code, a charge for a summary conviction offence must be brought within six months of the offence occurring.

These penalties are significantly lower than those contained in other child welfare legislation in Canada and are not sufficient to be a deterrent for persons who may intentionally violate the mandatory reporting procedures. The maximum penalties should be greater and be specifically set out in the Act.

It is recommended that:

The Child and Family Services Act be amended to set a maximum penalty for failing to report as required in section 18; and, that the maximum penalties be, at minimum, a fine of $2,000.00, a one year prison term, or both.

The six month limitation period for laying a charge is problematic. The situation at Knowles Centre in 1991 suggests this limitation period should be increased to allow for proper enforcement of the Act. This could be done by designating failure to report as a continuous offence. An alternative is to use the approach of The Environment Act wherein prosecution may not be commenced more than one year after the date on which evidence of the offence came to the attention of an environment officer.

It is recommended that:

Failure to report as required in section 18 of The Child and Family Services Act be designated as a continuous offence.
or,

The Act be amended to provide that a prosecution for failure to report as required in section 18 may not be commenced later than one year after it came to the knowledge of an agency or the Director.

E. PENALTIES FOR FAILURE TO REPORT BY PROFESSIONALS

A number of jurisdictions including Ontario, New Brunswick and Nova Scotia impose greater penalties on certain professionals for failure to report a child in need of protection.

For example, Section 24 of the Nova Scotia Children and Family Services Act provides:

> "24(2) Notwithstanding any other Act, every person who performs professional or official duties with respect to a child, including;
>
> (a) a health care professional, including a physician, nurse, dentist, pharmacist or psychologist;
>
> (b) a teacher, school principal, social worker, family counsellor, member of the clergy, operator or employee of a day-care facility;
>
> (c) a peace officer or a medical examiner;
>
> (d) an operator or employee of a child-caring facility or child-care service;
>
> (e) a youth or recreation worker;
>
> who in the course of that person's professional or official duties, has reasonable grounds to suspect that a

> child is or may be suffering or may have suffered abuse shall forthwith report the suspicion and the information upon which it is based to an agency."

The Nova Scotia Act sets the maximum penalty for any person who violates 24(2) at $5,000 or imprisonment for one year or both whereas the penalty for members of the public is limited to $2,000 and imprisonment for one year. Greater penalties for professionals recognizes the higher duty of persons who work with children. This is particularly important in the residential care system.

It is recommended that:

> The Child and Family Services Act be amended to provide that where a person violates the mandatory reporting provisions whose occupation, profession or official duties involves the care, custody, control or charge of, or unsupervised access to children be subject to a maximum penalty of a fine of $5,000.00, a one year prison term, or both.

Under section 18.2(1), at the Director's discretion, a person who has failed to report may be reported to a professional society, association or other regulating body. There is no justification for the Director having the discretion to report where the person's occupation, profession or official duties involves care custody, control, or charge of or allows unsupervised access to children.

It is recommended that:

Section 18.2(1) of The Child and Family Services Act be amended to require the Director to report to the relevant professional society, association or regulatory body when the Director has reasonable grounds to believe that a person has violated section 18 and that person's occupation, profession or official duties involves the care, custody, control or charge of or allows unsupervised access to children.

F. PENALTIES FOR INTERFERENCE OR HARASSMENT

Section 18.1(3) provides that no person shall interfere with or harass an informant. Section 18.3 makes such interference or harassment a summary conviction offence. Intentional interference with a person who wishes to report suspected child abuse should be subject to penalties at least equal to those being proposed for failing to report. Also, the limitation period for laying a charge should be longer than six months.

It is recommended that:

The Child and Family Services Act be amended to provide a maximum penalty for interfering or harassing an informant; and, that the maximum penalties be no less than a fine of $2,000.00, a one year prison term, or both.

The Child and Family Services Act be amended to provide that a prosecution for interfering or harassing an informant cannot be commenced later than two years

after knowledge of the offence came to the attention of the Director.

While implementing the above recommendations would strengthen section 18.1(3), penalties would still apply only when it can be proved that an informant was harassed or interfered with when trying to make a report. The Act does not provide for sanctions to be applied to a person who either interferes with the process of reporting or attempts to obstruct an investigation after the report has been made. Consider the situation where a worker or supervisor at a residential care facility withholds information from a social worker investigating an abuse allegation or, where a supervisor threatens disciplinary action against a staff person if that staff person discloses certain information during an abuse investigation. In both situations, the actions described would seriously impede the investigative process but neither may constitute interference or harassment of an informant.

A separate section in the Act is needed to deal with persons who impede or obstruct reporting or an investigation of suspected child abuse.

The Fatality Inquiry Act contains such a provision. 37(3) states that anyone who prevents, obstructs or impedes a medical examiner or investigator in the performance of his or

her duties is guilty of an offence punishable by a fine of $1,000.00. Section 37(4) lists the conduct that is deemed to be obstruction for purposes of the Act. The Child and Family Services Act should contain a similar wording.

It is recommended that:

A section be added to The Child and Family Services Act to stipulate that no person shall interfere with, impede or obstruct or attempt to interfere with, impede or obstruct the reporting or investigation of a child in need of protection.

A section be added to the Act which states that anyone found to violate the clause recommended above is guilty of an offence and liable to a fine of up to $2,000.00, a one year prison term, or both.

The penalties for interfering/harassing an informant or impeding or obstructing would apply to all persons. As with failing to report, the Review Team believes that a higher duty should apply to certain professionals. Anyone whose employment involves the care, custody, control or charge of children has a duty to be sensitive to the serious effects abuse can have on a child. This is especially true for residential care workers and staff in youth corrections, most of whom are working with children who have a history of abuse. Anyone working with children who intentionally impedes or obstructs a report or an investigation is committing an act paramount to child abuse.

It is recommended that:

The Child and Family Services Act be amended to impose higher penalties for a person found to have interfered with or harassed an informant when that person's professional, official or employment duties involves the care, custody, control or charge of a child or permits unsupervised access to children.

Maximum penalties for these offences be set at a fine of $5,000.00, a one year prison term or both.

Where a person works directly with children, and there are reasonable grounds to believe he or she committed an interference or obstruction type offence, it is imperative that the person's place of employment and professional society be notified. Action by the employer may be necessary to ensure that children are not needlessly placed at risk. This would build an additional safeguard and deterrent into the system.

It is recommended that:

Section 18.2(1) of The Child and Family Services Act be amended to require the Director to report to the relevant professional society, association or regulatory body and to the person's place of employment when the Director has reasonable grounds to believe that a person has committed an interference or obstruction type offence.

G. PENALTY FOR FALSE REPORT

The issue of false reporting is of tremendous concern to those working in the residential care system. A

person's career, reputation and standing in the community can all be compromised because he or she has been accused of abusing a child. Even if the allegation is unfounded or proven false, the damage to the accused person's life may have already been done. This is a very real and serious risk of working in residential care with children.

The Act must try and strike a balance to provide some protection for those who work with children on a day to day basis. If there are severe repercussions for persons who do not abide by the mandatory reporting requirements, there should be similar consequences for a person who falsely and maliciously makes a report that a child is in need of protection.

It is recommended that:

The Child and Family Services Act be amended to provide that no person shall falsely and maliciously report information to an agency that a child is in need of protection and that any person who does is guilty of an offence and is liable to a maximum fine of $2,000.00, a one year prison term, or both.

H. ENFORCEMENT OF THE ACT

A matter of concern is the lack of enforcement of sanctions in the Act. Information was provided to the Review Team that there have been several situations which may have

provided the basis for a charge or a report to a professional organization. These situations were known to one or all of the Director, police, and Department of Justice officials. Nc charges were laid or reports made, nor does it appear that consideration was given to doing so. The effectiveness of any legislation is seriously compromised if it is not enforced.

It is recommended that:

The Minister of Justice issue a directive to law enforcement agencies that charges be laid in all cases where there are reasonable and probable grounds to believe that a breach of the Act has occurred.

The Crown implement a policy of prosecuting all breaches of the Act.

CHAPTER IV

CHAPTER IV - LICENSING AND STANDARDS

Two statutes govern children's residential care facilities: The Child and Family Services Act and The Social Services Administration Act. Both Acts are administered by the Minister of Family Services.

Any person wishing to operate a home or facility for the care of children is required to have a licence. Section 8(1) of The Child and Family Services Act reads:

> "No person shall operate a foster home, treatment centre, or other child care facility, without a licence from the minister for the purpose, issued in accordance with the regulations under this Act or under The Social Services Administration Act or The Community Child Day Care Standards Act."

Although foster home, group home, and treatment centre are defined in the Act the term "other child care facility" is not defined.

The corresponding sections of The Social Services Administration Act require that anyone operating a facility for the care of children must have a licence for that purpose:

> "12(1) Notwithstanding the provisions of any other Act or of any by-law of a municipality, no person shall operate (a) any child care facility of the type listed in subsection 8(1) of the Child and Family Services Act ... unless that person obtains a licence from the minister for the purpose issued in accordance with, and subject to, the regulations under this Act or the Child and Family Services Act."

The designated licensing authority is the Office of Residential Care Licensing, located in the Management Services Division of the Department of Family Services. This office was established in 1981 and is responsible for all residential care facilities in Manitoba including foster homes, open custody homes, children's residential care facilities, adult residential care facilities and personal care homes. Responsibility does not extend to the two youth correctional facilities.

Sections 86(b) and (f) of The Child and Family Services Act allow for the issuance of regulations with respect to children's residential care facilities. This has not happened. Instead, Section 8(1) provides for the regulation of children's facilities under The Social Services Administration Act and Regulation 484/88R - Residential Care Facilities Licensing Regulation. Residential Care Licensing administers The Social Services Administration Act, Regulation 484/88R, and has developed accompanying standards.

Thus, licenses are not issued to facilities under The Child and Family Services Act. Having two statutes which apply to the same class of facility divides responsibility between the Directorate and Residential Care Licensing. The Directorate is responsible for funding, program issues and quality assurance while Residential Care Licensing is responsible for administering the regulations with respect to the physical aspects of facilities and the basic care and maintenance of residents.

Both The Directorate and Residential Care Licensing have developed standards which apply to their respective areas of responsibility. The two jurisdictions frequently overlap and conflict particularly where care of clients is concerned. It is often difficult to determine where a "facility" or "basic care and maintenance" issue ends and a "program" or "quality assurance" issue begins. For facility operators the result is a good deal of confusion and frustration as they attempt to satisfy the requirements of two statutes, one set of regulations and two sets of standards.

A. UNLICENSED FACILITIES

There are a number of facilities which provide residential care for children which are not licensed pursuant to section 8(1) of The Child and Family Services Act. These include the two young offender's facilities, St. Amant, and the Seven Oaks Centre for Youth.

1. Young Offender's Facilities

Responsibility for monitoring and reviewing the youth centres rests with the Corrections Division of the Department of Justice. The centres are not required to have a license and thus are not subject to review by Residential Care Licensing.

The Corrections Division has recently instituted an Operational Review process to be applied to all adult and youth corrections facilities. The Review is conducted by a team of 5 - 6 individuals from Adult and Youth Corrections. The Review is comprehensive in scope and is intended to ensure compliance with Departmental policies and practices.

There is a need for the Review to take into account the basic standards set out for children's residential care facilities. In particular, it is important that the youth centres have the same reporting policies as those which apply to children's residential care facilities. Incorporating

standards into the review process would ensure that similar standards are applied across the children's residential care system.

Open custody homes are licensed under The Social Services Administration Act. This is done through a delegation of licensing authority to the Provincial Director of The Young Offender's Act. It is not clear why the two youth centres are not licensed. In their "Mission Statement" Community and Youth Corrections perceive themselves as caregivers not unlike the child and family services residential care settings. Juvenile Counsellors have many of the same duties and responsibilities as youth care workers. A number of other jurisdictions include young offenders facilities in their child welfare facility licencing regimes.

A separate issue with respect to the youth centres concerns those clients who are both wards of the Director and are in custody. There is a need for greater interaction and cooperation between Youth Corrections and Child and Family Services concerning joint clients as well as those youth in custody who may be referred to an agency or be in need of protection. The two departments need to discuss the extent to which children's residential care facility regulations and standards should apply to the youth centres. At minimum, since youth centres must also comply with the reporting

requirements of The Child and Family Services Act, the standards for services to young offenders should be amended to provide more comprehensive information on reporting and investigating allegations of abuse in youth correctional centres.

It is recommended that:

All Young Offenders facilities be licensed pursuant to section 8(1) of The Child and Family Services Act.

The Minister of Family Services delegate licensing authority to the Provincial Director of The Young Offenders Act similar to what is done for open custody homes.

The operational reviews incorporate relevant Child and Family Services Standards for children's residential care facilities.

The Child and Family Services Standards related to services for young offenders be amended to provide a more comprehensive protocol for reporting and investigating allegations of abuse in young offender's facilities.

2. St. Amant Centre

The St. Amant Centre is a large residential facility in Winnipeg for disabled children and adults. It is accredited as a health care facility. Parents place children in St. Amant through a Voluntary Placement Agreement arranged with a mandated agency.

St. Amant Centre is funded by the Children's Special Services Branch of the Department of Family Services. This Branch is not part of the Child and Family Services Division.

Although St. Amant's group homes are licensed the main residential facility is not. The reasons for this are not clear. St. Amant appears to meet the definition of a children's residential facility within the meaning of section 8(1) of the Act and should be subject to the licensing requirements.

As the funding body, responsibility for monitoring the children's programs appears to rest with the Children's Special Services Branch. This Branch does not conduct regular program reviews at the Centre. It is not clear which program standards would even apply. Standards set by Residential Care Licensing are not used as the main facility is not licensed and the Child and Family Service Standards are not used as funding comes from a separate Branch. As a result, no formal process exists for ongoing monitoring of programs.

Regular program reviews are essential to ensure that the mandatory reporting requirements are being communicated, understood and followed. As a children's residential facility, program standards should be set and moni-

tored by the Director particularly since the placements are being supervised by an agency. The main facility should be licensed under the proposed regulation for all children's residential facilities. Program reviews should be done regularly taking into account the special developmental needs of the children. These reviews should be the responsibility of the Director who has the legal obligation to supervise placements and ensure the safety of children. This should be done separate and apart from the health facility accreditation process.

It is recommended that:

St. Amant Centre be licensed as a children's residential care facility pursuant to section 8(1) of the Act.

The existing standards be amended to include special services for disabled children in care.

The Department of Family Services clearly articulate that standards for programming at St. Amant Centre are to be monitored under the jurisdiction of the Director of Child and Family Services.

3. Seven Oaks Youth Centre

Seven Oaks is designated as a "place of safety" pursuant to The Child and Family Services Act. Unlike other residential care facilities, it is operated directly by the Department of Family Services, reporting to the Director.

The Centre is the only locked receiving facility in the Province.

Seven Oaks is intended for high risk children. The admission policy requires that children meet at least one of the following five secure admission criteria:

- Chronic sniffer/substance abuser combined with chronic running which poses an immediate threat to the child.
- Child with medical/psychiatric validation as being a suicidal risk, but security and protection are also a major issue.
- Child with medical condition evaluated by medical doctor whose life is at risk because of his/her lifestyle.
- Obvious life threat, that is, child's life has been threatened.
- Child's behavior that poses a serious/immediate threat to the safety of others.

As a receiving facility, placements are intended to be short term. Child and Family Services Standards specify that placements in a receiving facility should not exceed thirty days. Children routinely remain in Seven Oaks well in excess of this. It is not unusual for there to be children in Seven Oaks for over ninety days. As at the date of this

report, one child has been in Seven Oaks for 284 consecutive days. This is unacceptable.

Seven Oaks has been the subject of considerable scrutiny over the last year. In December 1991, the Provincial Ombudsman released a report concerning a review of handling of abuse allegations at the Centre. A copy of the Ombudsman's report was made available to the Review Team. Information provided to the Review Team, independent of the Ombudsman's report, supports many of the Ombudsman's findings and recommendations.

There are a number of issues relating to the program, management and staffing of Seven Oaks that are of great concern and which must be addressed immediately.

(a) Seven Oaks offers no treatment. Children who meet the admission criteria are some of the most damaged children in the system and should not be housed without treatment. This is particularly unacceptable when placements go beyond thirty days.

(b) Children with destructive/violent behavior, who have a history of gang or cult involvement, and known sexual offenders, are placed with some of the most vulnerable children in the system. This

creates safety risks. In these situations, Seven Oaks is not always able to put appropriate safeguards in place to protect children from each other.

(c) Children with severe psychiatric disorders are often placed in Seven Oaks as there are no mental health resources available. Seven Oaks is not able to meet the needs of these children.

(d) Although there are some very skilled staff at Seven Oaks, many lack the knowledge and skills necessary to meet the complex needs of children placed there. Staffing levels are often inadequate.

(e) Despite locks on the doors, at any given time there is an alarming number of children AWOL from the facility. Many children have repeated admissions resulting in the "revolving door syndrome".

(f) The locked setting and historical background of Seven Oaks encourages a "jailkeeper" mentality. Inclusion in the corrections component of the Manitoba Government Employees Association reinforces this.

(g) Management appears to be unaware of, or ineffective in dealing with, a variety of inappropriate practices by staff and supervisory personnel.

(h) Seven Oaks does not, nor does management consider it should, comply with Child and Family Services Standards that apply to residential care facilities.

(i) There is a lack of external accountability. Operated by the Department, it is not governed by a Board, not licensed under the Act, and not monitored by Residential Care Licensing. The Directorate does not conduct regular reviews.

(j) Despite the deficiencies identified by a number of reports in the past, including that of the Ombudsman, little has happened to improve the situation at Seven Oaks. The system appears unwilling to address such concerns.

There are also larger issues concerning the role and function of Seven Oaks that raise questions about its continued existence. This is not a novel notion. In 1987, the Reid/Sigurdson Report questioned the appropriateness of

such an institutional setting as a receiving resource for children.

There is a need for an emergency placement facility for high risk children, and it may well be that such a placement ought to be secure. However, the deficiencies in the organization and operation of Seven Oaks have led to unacceptable conditions. This situation cannot continue.

It is recommended that:

An immediate management review of Seven Oaks be conducted.

A management committee be appointed forthwith to oversee the operation of Seven Oaks. This committee should be given the usual powers and authorities of a Board of Directors.

Seven Oaks be licenced pursuant to Section 8(1) of the Act.

The Department work in conjunction with the Manitoba Government Employee's Association to have employees moved to the social services component of the Collective Agreement.

The Department work with the Department of Health to ensure appropriate placement resources for children needing psychiatric services.

The Department develop a three year plan to close Seven Oaks, and replace it with alternative receiving resources.

B. REGULATIONS AND STANDARDS

Regulation 484/88R contemplates that developmental program issues (such as treatment for example) will be handled by the "appropriate authority". In the case of children's residential facilities this refers to the Directorate.

The Social Services Administration Act and its Regulations are designed to apply universally to both children's and adult's facilities. Because children's residential care facilities are included with adult's facilities, this universal approach means that the regulations are not sensitive to the unique needs of children in care. At the same time, Regulation 484/88R does not acknowledge reporting requirements in The Child and Family Services Act. This results in unnecessary overlap, confusion and conflict with respect to a number of provisions relevant to this Review, including basic programming, a child in need of protection, the definition of abuse, and reporting and investigation of incidents.

1. Basic Programming

Child and Family Services Standards and Residential Care Licensing Standards overlap in a number of program areas. Regulation 484/88R and Residential Care Licensing standards incorporate a number of facility and program components that are also addressed by the Child and Family

Services Standards. This includes matters related to a resident's personal effects, medication, recreation/leisure activities, health, personal hygiene, safety, restraint, incident reporting, and monitoring and reviewing. Often the wording is inconsistent and expectations of facilities are decidedly different. Two examples are restraint policies and the monitoring of programs.

Section 20 of The Social Services Administration Act Regulations states that an operator shall not abuse a resident or restrain a resident (unless for momentary protection of person or property and approved by a resident's physician). Section 8.3 of the Residential Care Licensing Standards provides that restrictions on a resident's freedom of choice, behaviour or decision making are allowable only to the extent necessary to ensure a resident's health and safety. Restraint should be used only as a last resort, restraints are to be fully documented and reviewed by the supervising agency and only those restraint methods approved by the supervising agency are used. Injury to a resident as a result of restraint is to be reported as per incident reporting requirements.

Child and Family Services Standards also have a policy on restraint. Section 457.1 provides that acceptable disciplinary methods include physical restraint for the sole

purpose of protecting people and property only to the degree necessary. Section 457.4 provides that prohibited methods of discipline include mechanical or excessive restraint and prolonged confinement to bed. Details of restraint incidents are to be outlined at quarterly conferences with social workers.

Since Residential Care Licensing Standards do not make the distinction between adult and children's facilities the restraint provisions overlap with those in Child and Family Services Standards. Operators could satisfy one set of criteria while violating another.

Residential Care Licensing Standards presume a level of monitoring and review of facility programming that does not occur. Section 5.2 provides that on the advice of an agency a license may be cancelled. The guideline states that the agency is responsible for monitoring program standards and initiating remedial/corrective action as necessary. Where this fails, agencies are to notify Residential Care Licensing and the reasons for recommending cancellation. It is evident that monitoring of residential care facilities is minimal to non-existent.

2. **A Child in Need of Protection**

The requirement to report a child in need of protection is neither referenced nor incorporated in Regulation 484/88R. The definition of "abuse" in this regulation is not consistent with that which is contained in The Child and Family Services Act.

> Regulation 484/88R defines abuse as:
>
> "physical punishment, threats, verbal or non-verbal coercion directed toward any resident, or the withholding of a resident's regular meal, money, or other personal property, or medication or aid necessary for the proper physical functioning of a resident; ...".
>
> The Act defines abuse as:
>
> "an act or omission of a parent or guardian of a child or of a person having care, custody, control or charge of a child, where the act or omission results in
>
> (a) physical injury to the child,
>
> (b) emotional disability of a permanent nature in the child or is likely to result in such disability, or
>
> (c) sexual exploitation of the child with or without the child's consent; ...".

An operator of a facility is required to refer to both statutes or standards when determining whether an inci-

dent is reportable and to whom. To their credit most facilities have managed to "dance" their way through this maze of requirements. However, having two definitions of abuse often leads to needless confusion and frustration.

3. Reporting

While every citizen is required to report a child in need of protection under the Act, Regulation 484/88R also requires the reporting of an "incident" or change in a resident's condition. Section 18(1)(f) and (g) state the operator of a facility shall:

> "advise the supervising agency of any serious change in condition, illness or death or unauthorized absence of a resident within 24 hours of the occurrence thereof; and
>
> advise the Licensing authority of, and investigate, any accident or incident which jeopardized the health or life of a resident to ascertain the circumstances of the accident or incident and institute appropriate measures to prevent similar occurrences in the future."

Reporting requirements are outlined in Appendix B of Residential Care Licensing Standards. An incident is defined as "some occurrence which causes loss or injury to or adversely affects the health, life, safety or well-being of a resident." Although the definition of "incident" is very similar to the wording in Section 17(1) of The Child and

Family Services Act, a child in need of protection, this appears to be coincidence rather than by design.

Incidents are either resident or standards specific, and types of incidents falling into each category are described. The operator is to determine into which category an incident falls and reports to both the agency and Residential Care Licensing by telephone, within 24 hours. By contrast Section 475 of Child and Family Services Standards requires that any incidents of sexual abuse be reported to the agency immediately.

Residential Care Licensing Standards for reporting abuse are based on Section 20(a) of Regulation 484/88R which provides that "the operator of a residential facility shall not abuse a resident ...". Part 8.2 of Residential Care Licensing Standards requires that all allegations of abuse and/or suspected abuse be reported to the Licensing Authority. Conversely under The Child and Family Services Act, abuse is to be reported to an agency.

The Child and Family Services Standards also contain provisions regarding the reporting of incidents. Section 459 requires that incidents concerning a child are to be reported by the care provider in accordance with provincial policies and procedures. This does not address the first

party obligation to report a child in need of protection. This wording needs to be clarified to address the mandatory reporting provisions of the Act.

Section 475 of the Child and Family Service Standards specifies procedures for reporting allegations of child sexual abuse. It is not clear why sexual abuse is distinguished from other forms of abuse or other reasons for a child being in need of protection. Residential care providers are to notify the placing agency as soon as possible and Residential Care Licensing within 24 hours (or the next working day) by phone. Residential Care Licensing Standards do not state the need for immediate notification to the placing agency in relation to incidents of abuse or other incidents causing a child to be in need of protection.

Section 475 also provides that workers who receive disclosures or suspect sexual abuse are to first consult with the facility's director before reporting. The director of the facility is to make the report to an agency. Only in the absence of the director is the facility staff to contact the agency. This violates the mandatory reporting requirements of the Act. To add to the confusion, the procedures that are to be followed in Section 475 require that the staff who receives the disclosure from a child, also tell the child

that the staff person, (not the Director of the facility) will give the information to the child's agency worker.

Where incidents of abuse are disclosed to or observed by a staff member, there may be a need for consultation with superiors, an agency or the licensing/program authority. This would allow the person who received the disclosure or observed the incident an opportunity to clarify whether the incident is in fact reportable or to clarify to whom the incident should be reported. It is also the case that the needs of the child, professional courtesy and effective administration all require that in most situations senior staff should know of the intent to report by one of their staff. In all circumstances, however, the Standards should clearly state that it is the legal responsibility of the person who first receives information about a child being in need of protection to report "forthwith" to an agency. Section 18.4(1) of the Act provides that it is the responsibility of the agency to assess the incident as to whether it involves a protection issue and requires investigation. The involvement of other authorities should follow after, or in tandem with, but never ahead of the agency.

Section 475.3 of the Child and Family Services Standards requires facilities to have a written policy with respect to reporting of an allegation of sexual abuse against

a staff member. While most facilities have a policy for reporting incidents, many do not have a policy specific to an allegation against staff.

Section 473.9 creates further confusion. All incidents of employee misconduct are to be reported to the facility director who is to report the incident to an outside authority only if it involves a criminal offence. Otherwise, the matter is to be handled internally.

Children who are absent without leave from a residential facility represents another example of differences in reporting requirements. Regulation 484/88R requires facilities to advise the supervising agency of any unauthorized absence of a resident within 24 hours. The Child and Family Services Standards require unauthorized absences from children's facilities to be reported to police after six hours have elapsed or immediately if the child is in danger. The supervising agency is to be notified within 24 hours.

Recently, Residential Care Licensing and the Directorate prepared a revised protocol with respect to the incident reporting policy applicable to licensed facilities. The draft protocol establishes one central reporting location for all incidents arising from residential care facilities. This

central body would then refer reports to the appropriate authority as required.

This represents an improvement over the existing situation. Reference is made in the protocol to the fact that incidents placing a child in need of protection should be reported according to the Directorate's Guidelines. However, it is still somewhat confusing in that it separates incidents into what is reportable to Residential Care Licensing and what is reportable to an agency. It also indicates that all incidents reportable to Residential Care Licensing must also be reported to an agency.

The end result of this surfeit of regulations, standards and guidelines governing the reporting of incidents in residential facilities is that operators must make four copies of each report (one for each of the agency, Residential Care Licensing, the Directorate and themselves). A facility can receive different responses. For example, Residential Care Licensing will respond to incident reports from facilities using a form letter. This often indicates that the facility has conformed with licensing standards, while at the same time, if the incident has any program aspects, the Directorate may also respond and might suggest that the facility is not conforming to program standards.

This causes great confusion and frustration on the part of facilities.

4. Investigations

Part 8 of the Residential Care Licensing Standards state that the Licensing Authority is responsible for the investigation of all allegations of suspected instances of abuse. The investigation is to be conducted according to established departmental protocols. This is contrary to The Child and Family Services Act, which provides that an agency is responsible for investigating incidents involving a child in need of protection.

Appendix C in the Residential Care Licensing Standards sets out the procedures for investigations. Residential Care Licensing is the contact point for all incidents/complaints concerning residential care facilities. All reports are to be reviewed by Residential Care Licensing and referred to the appropriate agency, office, or authority having jurisdiction. Where a report is resident-specific the guardian/next-of-kin is to be notified, receive copies of reports and findings from the investigation. Reports are to be prepared by the appropriate authority in conjunction with Residential Care Licensing. If an allegation is unsubstantiated a copy of the findings is to be forwarded within two weeks to the operator and the complainant.

According to section 475.5 of the Child and Family Services Standards facilities can expect written feedback from the agency on a plan of action to investigate. No reference is made concerning what information a facility should receive concerning the results of that investigation. Residential Care Licensing Standards state that findings will be provided to the facility and others. Section 18 of The Child and Family Services Act provides that certain persons will be notified about the results of investigations only where a child is determined to be in need of protection.

5. Conclusion

In conclusion, there is much overlap and many inconsistencies between the two sets of standards, between the standards and regulations, and between the two Acts. This leads to needless confusion, uncertainty and duplication concerning what to report and to whom. It also wastes time and causes a great degree of frustration for facilities and workers.

Standards should flow from legislation and offer further clarification and explanation, not re-interpret or contradict the Act. It cannot be emphasized too much that it is inappropriate to have two sets of standards in place for

children's residential facilities. It is even more inappropriate to have a single set of standards for significantly different classes of operations (i.e., children's versus adult care facilities).

It is important to end the confusion created by the current regime of legislation, regulations, guidelines and standards.

Under The Child and Family Services Act the Director is responsible for placement resources. The Director should be responsible for monitoring and reviewing facilities to ensure compliance with standards. There should be one set of regulations and one set of standards with respect to children's residential facilities pursuant to The Child and Family Services Act. The existing manuals should be combined and reviewed to ensure consistency with respect to The Child and Family Services Act and regulations.

It is recommended that:

The Director of Child and Family Services be the designated licensing authority for children's residential care facilities.

Regulations be developed pursuant to The Child and Family Services Act setting out the licensing criteria for children's residential care facilities.

One specific set of standards be developed for children's residential care facilities.

The standards contain a separate section on reporting where a child may be in need of protection.

The standards include a uniform policy for reporting to be utilized by all children's residential care facilities.

The uniform reporting policy:

- clearly state the first-disclosure recipient is responsible for reporting to an agency;
- encourage consultation with experts external to the facility such as the police, an agency or the Directorate;
- where the alleged offender is a staff member, require steps to be taken to ensure the staff member is to have no contact with children in the facility until an investigation is completed, and that the Board of the facility be notified to the report;
- where the alleged offender is in a management position, or there is reason to believe management had prior unreported knowledge of the incident, that management not be notified of the report and, the Board of the facility be notified after a report has been made to the agency;
- a staff be provided with a copy of the uniform policy and be required to sign an acknowledgement that they have read and understood the policy.
- facilities provide the Directorate with a copy of all signed acknowledgements from staff.

C. INTERNAL REPORTING POLICIES OF CHILDREN'S RESIDENTIAL CARE FACILITIES AND YOUTH CORRECTIONAL FACILITIES

Section 459 of the Child and Family Services Standards requires residential care facilities to follow established provincial policies and procedures for incident

reporting. Section 475 of the Standards deals specifically with the reporting of a disclosure of sexual abuse, and requires facilities to have a written policy for dealing with an allegation of sexual abuse made against a staff member. The Standards do not specify or provide guidance on the form or content of that policy.

The survey conducted during the Review asked facilities to attach a copy of their policy to the completed questionnaire. Approximately 90% of facilities indicated they had a policy on reporting of abuse, although twenty percent were unable to provide a copy of their policy. Most policies reviewed by the Team were consistent with the mandatory reporting requirements in the Act. Few policies dealt with allegations against staff specifically.

Approximately 10% of facilities had no policy at all, while others had a policy that required a disclosure be reported to a supervisor, who was expected to report the information to an agency if the child was considered to be in need of protection.

In young offenders facilities The Community and Youth Corrections Division Manual outlines reporting procedures and the investigation process where a child is in need of protection.

Reporting policies place a precedence on reporting upward through the administrative structure. The person who received the information concerning abuse gives it to the In-Charge person who then notifies the agency. Again, it may be administratively appropriate for management to be aware of abuse reports, but the necessity to report internally should not take precedence over the legal requirement for the first person report to any agency.

It appears that in both facilities the possibility exists that an investigation of a child being in need of protection could be pre-empted or interfered with by the internal practices.

In youth correctional facilities, incidents between residents or between staff and residents are often viewed as assault rather than a matter of protection. Internal reporting policies for assaults provide for parents or guardians to be notified but not an agency.

MYC has its own internal process for an investigation as well as a statement concerning the involvement of Child and Family Services agencies, parents and/or guardians including group homes and foster homes. Agassiz has limited policies on reporting.

The Manual indicates that a written response including the results and any course of action is expected from an investigating agency within three weeks of the report/referral. The Child and Family Services Standards contain a similar protocol concerning young offenders.

The reporting policies in youth correctional facilities must be consistent with the mandatory reporting requirements of The Child and Family Services Act.

It is recommended that:

The Department of Justice, in conjunction with the Department of Family Services, review the internal policies for reporting suspected child abuse at the youth correctional facilities to ensure consistency with the definition of a child in need of protection and mandatory reporting in The Child and Family Services Act.

All youth correctional facilities adopt the Uniform Reporting Policy contained in the Child and Family Service Standards.

D. THE REPORTING PROCESS - DESCRIPTION AND ISSUES

Given that The Child and Family Services Act takes precedence over regulations and standards, and considering the provisions of all three, the process of reporting can be summarized as follows:

Once information is received that causes a staff person to believe a child is in need of protection, the staff person must ensure the child is not in further danger and shall make the child feel safe. The incident is then forthwith reported to an agency by telephone and Residential Care Licensing is to be informed within 24 hours. A written description of the incident is completed and forwarded to the agency, Residential Care Licensing, and the Directorate within five days. A copy is kept by the facility.

After reporting the incident to the agency, the staff person then provides the same information to the management of the facility. Where the incident involves line staff there should be no discussion of the incident with other line staff. If the incident involves a senior staff person then the report should only be made to the agency, Residential Care Licencing and the Directorate. If the facility is a private organization with a Board, a report of the incident is also made to the Board.

On receipt of a report, the agency, in consultation with the facility, shall decide how to proceed after the agency considers the need for a medical examination, involvement of the police, and an immediate plan for the child. The agency contacts the police and an appropriate time to see the child is arranged. The agency provides a written plan of

action to the facility. Contact with the family of a child is a joint decision of the facility and agency. The child is to have no contact with the "offender" until a joint decision of the facility/agency can be made.

The role of the facility is to assist in any investigation which may occur. If, based on the investigation, the agency concludes that the child is in need of protection, the agency shall take further steps as required or as is considered necessary to protect the child. In all cases of child abuse the police are to be notified and consulted. In cases of physical abuse, police are to be notified immediately and should only investigate if criminal charges are likely. In sexual abuse cases the police are consulted and usually take the lead in the investigation unless this is inappropriate or not possible. If not possible, the agency conducts an investigation regardless of the impact it may have on future criminal processes.

The Child and Family Services Act requires an agency to report the results of the investigation, if the child is found to be in need of protection, to a number of persons including the facility, the child (if appropriate), and the person who made the report. If the alleged offender is a staff person and is charged criminally, the Act also provides that the employer is notified.

If the child is found to be in need of protection, the agency is to refer the report to the agency's Child Abuse Committee within 14 days and the Committee is to review the referral within 21 days of receipt. The facility staff are to attend the Abuse Committee meeting which considers the case of a specific child from their residence.

While the above represents the intended process for reporting it does not always occur as required and for a variety of reasons.

1. Learning That Abuse Has Occurred

The first step in the reporting of any incident is receiving information that some behaviour has occurred that might endanger the life, health or well-being of a child. The likelihood that such information will be received will vary depending on the nature of the abuse. By its very nature, sexual abuse occurs in secrecy. Thus, unless a child discloses, rarely will there be an opportunity to learn of the behavior.

The factors which affect whether a child will disclose are as complex as they are numerous. Children sometimes do not recognize abuse. Some have been victimized from

very early ages, and abuse has become normalized for them. Victims of abuse often mistake attention for affection.

Emotional and physical abuse in some ways are easier to learn about. They too may be difficult for many children to identify because they have been normalized, but it is generally the case that both the abuse and the offenders are not as subtle. Physical harm often leaves visible results.

A pre-condition for a child disclosing abuse is the notion of feeling safe. Fundamentally, a child must trust the recipient of the disclosure not to hurt him/her or allow him/her to be hurt further. Again, what makes a child feel safe is greatly influenced by the particular child, and his/her history. Some children disclose abuse almost immediately. Others never will. A child's previous experience with disclosing - and what happened as a result, the nature of the abuse that is occurring, including the extent of any intimidation or threats, the proximity and position of the abuser and whether the child perceives that the abuse can be stopped, are all significant factors. The crucial factor, however, is that the child must feel that the person being told both supports and can protect the child.

In addition, children often use subtle and complex ways of imparting messages. Many say things indirectly or only give hints. Some act out. Thus, the knowledge and skill of the recipient of the disclosure is very often a critical factor in recognizing a disclosure.

Sexual abuse is a particularly complex matter. An interesting observation by those who have worked in residential care for many years is how few disclosures of sexual abuse occurred even ten years ago. It is now recognized that abuse was occurring. However, it was only when professional caregivers accepted that sexual abuse happened, that significant numbers of disclosures occurred. For most, it begs the question: Were children trying to tell, but no one heard? Or were they not telling because they knew they would not be believed?

2. Recognizing the need to protect

The Act provides that a child is in need of protection if his/her life, health or emotional well being is endangered by the act or omission of a person. What is seen as a situation where a child needs protection varies greatly within residential care. Many facilities tend to report anything that is questionable. This seems to be borne out of the fear of not reporting something that should be reported,

rather than a clear understanding of the fundamental notion of a child being in need of protection.

There are two situations which suggest this is so. The first is resident on resident assaults. Often staff focus on the question of who has caused the child harm. Where one resident assaults another, since a child is not in the care, custody, or control of the offender, no obligation to report is thought to exist. Others suggest that because a child is in care, he/she is already being "protected", so such an incident should be treated simply as a matter of assault and referred to the police authorities.

While a resident on resident assault may well provide the basis for a criminal charge, it may also indicate that the facility is unable to provide adequate care or supervision for the child, which by definition means the child is in need of protection. It may go even further to show that an omission of the facility has resulted in the harm. This comes within the definition of "abuse". Whether or not this is a protection issue will require some judgment. Except in very minor situations, this should be up to an agency and not the facility to determine.

The risk of harm from other children in facilities is significant for children in both residential care and

youth corrections facilities. It is essential that these situations be monitored.

The second situation is that of adult disclosures. Interviews conducted by the Review Team suggest that many staff recognize that a disclosure from an adult must be reported. However, where this knowledge exists, it seems to come from the attention paid to this issue as a result of the incidents at Knowles Centre. Only a very small percentage appear to appreciate the underlying basis for the reason to report.

The incidents at Knowles involved adults disclosing abuse that had occurred while they were residents there. The understanding of Knowles management was that since the individuals were adults at the time they disclosed, there was no obligation to report the disclosures. The fundamental question, however, was whether the incidents occurred as a result of Knowles' inability to provide adequate care for or supervision of children. If so, given that Knowles continued to have children in its care, the next question was whether Knowles was currently able to protect children. This uncertainty about adult disclosures is prevalent not only in residential care, but throughout child welfare as a whole.

Many staff do not appreciate that the obligation to report extends to any situation where a child is in need of protection, and use a very narrow definition of abuse.

Unfortunately, this is also the case with some agency workers. A number of situations were cited by facilities who received disclosures of abuse that happened to children prior to coming into care. When contacted, agency workers refused to investigate citing the fact that the child could not be in need of protection because he/she was in the care of the facility. While that might be so in some instances, the examples that are particularly troublesome are those where the alleged offender is a member of the community or family where the child will be returning.

Many staff also have little appreciation of what might endanger the emotional well-being of a child. Generally, youth care workers appear to recognize the fundamental need to treat children fairly, with respect, and in a non-punitive manner. However, this is not consistently the case and it is of concern that there are staff who, on a regular basis, use intimidation, coercion or negative power to control children. This behavior is not only unacceptable but can also be a protection issue. On the whole, it would appear that the most serious risk to children in facilities in terms of staff is of emotional harm.

This is both a training and supervision issue. It also speaks to a more basic problem relating to the values and attitudes of some workers and the environment that exists in some facilities.

Verbal or sexual intimidation or aggression between residents appears to be even less well recognized as a protection issue, particularly with girls.

3. Knowledge of Reporting Requirements

There is also wide variance in the degree of knowledge of the requirement to report. Interviews conducted by the Review Team revealed that by and large, most staff recognized that abuse (however they might define the notion), must be reported to an agency. This was not universally the case however. There is still a small percentage of staff who have little understanding of the obligation to report. Further, many staff had no appreciation of an individual's obligation to report directly and believed that advising their facility director was sufficient. Given the great confusion caused by the regulations and Standards, this is not surprising. It is a situation which must be corrected however.

Day Care regulations require that all centres cause staff to be instructed in the reporting obligations under the

Act annually. This is equally as necessary in the residential care system, and should address the many uncertainties.

It is recommended that:

Regulations be passed requiring all residential care facilities to instruct staff in the reporting requirements of The Child and Family Services Act at the time of employment and on an annual basis thereafter.

4. Factors that Affect Reporting

There are a number of circumstances that appear to, or might well, affect whether staff will report an incident.

Information available to the Review Team suggests that although few in number, there are some situations where staff feel intimidated and reluctant to report incidents for fear of retaliation by other staff. This is a matter of concern, and goes to issues of training, supervision and management of a facility. At a systemic level however, the process of investigating an incident is seen to be very unfair and is fraught with confusion and uncertainty at every step.

On the one hand, a facility may be subjected to intense scrutiny, and criticism by Residential Care Licensing, the Directorate, agency workers (often each resident will be interviewed by his/her respective worker), the pol-

ice, and sometimes even the media. It is not unusual for conflicting opinions, directions and advice to be given concerning every element of the incident.

At the same time, the opposite can occur. Occasionally no one seems interested in investigating and the facility is left to pursue a response. Residential Care Licencing and the Directorate wait for the agency to investigate. The agency waits for the police to decide whether they will investigate. If so, nothing further is done until the police investigation is over. Police investigations are notoriously slow, often taking months to complete.

If the police decide not to investigate, or do but no charges are laid, agency workers cannot be depended on to act promptly or thoroughly in conducting an investigation. Considerable skill is necessary to reach a conclusion as to where the truth lies in many of these situations. Good investigation techniques are essential. Surprisingly, agency workers receive no training in investigation techniques. Although there are many who are skilled in this area, those skills usually come from much experience and the good fortune of also having had a skilled supervisor. In addition, agency workers often carry unmanageable caseloads. Other priorities often take precedence over such investigations.

In addition, both facilities and agency workers expressed the view that the child's worker is perceived to be in a conflict of interest when asked to investigate an allegation of abuse against a facility staff given that the worker's role is to be the child's advocate. This notion is supported in other jurisdictions where standards require that investigations in residential or foster care shall not be conducted by the child's placing agency.

The disruption and anxiety to staff and children as a result of an allegation and the resulting investigation is considerable. The greatest concern of many staff interviewed by the Review Team is the penalty paid by children who disclose. The courage necessary for children to "tell" should not be minimized. The process is filled with secrets and uncertainty, and often replicates the abusive situation that brought a child into care in the first place. The weeks or months of waiting for a conclusion is very destructive and often undermines all the child has achieved while in the facility's care. Despite all they are told about how it is okay to talk about what has happened to them, surely the message that this process gives to children is that it is much wiser not to say anything.

For a staff person accused of wrongdoing, the process is a nightmare. Staff are usually sent home with no

explanation, sometimes with no guarantee of pay pending the outcome of the investigation. Prohibited from speaking with their co-workers about the matter, they must live day to day without any support from the system, wondering what will happen and often having no idea what they are alleged to have done. Frequently staff are not even asked their side of the story. If they are, of course, the question arises as to whether they should have a lawyer present. A daily phone call to their employer to see if there is any word as to when or if they will be able to return to work becomes their only contact with anyone outside their families. Often the matter ends with the agency worker calling the facility to say the staff person can return to work as nothing could be established. No further explanation is given. This is a most unsatisfactory situation.

Unless some fairness and balance can be brought to the process of investigating abuse allegations in residential care, it is unrealistic to expect that allegations or suspicions of abuse will be reported, particularly where the allegation is unclear or is capable of being interpreted in an innocent way.

This is not to say that the safety of children can ever be compromised. Clearly, when an allegation is made,

the staff person must not be allowed contact with children until the matter is resolved.

A solution to this situation would be to create a central investigation team charged with the responsibility of investigating any allegations against staff or residents in residential care facilities. This approach would eliminate the conflict of interest (particularly if the team is outside the child welfare system) and bring consistency to and reduce the time involved in completing investigations. It is crucial that the child's worker be involved in the investigation, certainly to make the initial assessment concerning the safety of the child, and to be part of the interview process with the child. It is also important that the outcome of investigations be better defined and communicated to bring closure to any incident.

There are four possible outcomes of an investigation of an allegation, three of which may result in further action or sanctions.

If a child is determined to be in need of protection, a breach of The Child and Family Services Act and possibly the Criminal Code has occurred. Court action may follow.

At the other extreme, an investigation may find that the allegation was falsely and maliciously made. This is another instance where court action may follow.

In between are two other possible conclusions. The investigation may determine that the allegation was unfounded. This would include situations where something has occurred which the child has perceived to be abusive but on investigation, it was determined that there was nothing inappropriate that occurred.

The investigation may find the allegation to be unsubstantiated, meaning there simply is not sufficient evidence to make a determination as to what happened. Often these situations involve questionable conduct or practice by staff. While this may not be a matter for police or agency intervention, it may raise issues relating to standards and job performance. Where the investigation finds that a standard has been violated or that a staff person has behaved inappropriately, this should be reported to the employer and the Directorate.

It is a reasonable expectation that every investigation should reach one of these four conclusions. The more precise the conclusion, the more likely it is that appropriate action can be taken. This is important to minimize

recurrence of preventable situations. This will also minimize the anxiety that staff, management and children all feel when there is uncertainty about the conclusion of an investigation.

A central investigation team would be able to address these situations.

It is important that the team develop a protocol setting out reasonable time limits, guidelines, and responsibilities of the team, agency workers and facilities. Establishing such a protocol would go a long way to reducing the anxiety felt by all who are affected by the process. A standardized form of report could be used which would classify results in terms of one of the four situations described above.

Currently, workers who investigate allegations in facilities often are not aware of any other incidents that might have happened, either in the facility or elsewhere in the system. Sometimes this is important information to have. A team would be in a better position to address trends that might be occurring in the system, or recurring problems that might exist in a particular facility.

Although this will not prevent those situations where police involvement results in lengthy investigations, it appears that by far, the majority of cases do not fall into this category.

This function is probably best assigned to the proposed office of The Children's Advocate. The training, experience, and credibility of the individuals who are selected for these positions is critical.

It is recommended that:

A central team be established to conduct investigations of allegations of abuse in children's residential care facilities.

The team be assigned to the office of The Children's Advocate.

A protocol for investigations be developed and circulated to all residential care facilities.

The Central Investigation Team develop a system to categorize conclusions of investigations. Any conclusions address concerns related to standards, appropriateness of behavior and job performance.

All conclusions be communicated in writing to the facility, the person accused, the agency, the child and the Directorate.

It is also essential that until such time as an investigation has been concluded, a worker who is suspended must be guaranteed his/her salary. Currently, facilities are not funded for replacement staff in such circumstances. A

number of facilities expressed the concern that if they were put in this position for any more than a few days, they would not be able to continue to operate. Again, such circumstances would not militate in favour of reporting. A fund for this purpose should be established to reimburse facilities for the cost of salaries of suspended staff.

It is recommended that:

The Department establish a fund to cover the salary of any employee suspended as a result of an allegation of abuse pending the conclusion of an investigation.

The need for staff support, both for individuals, and for workplaces is absolutely essential in this system, particularly when a critical incident such as an allegation against a staff person has occurred. A number of facilities have utilized an employee assistance program in such circumstances. They indicate that the entire facility benefits enormously from having an outside, independent and confidential resource to assist them in discussing their concerns, venting frustrations and working through what has happened. The system as a whole would benefit from such a resource. It would also be of great benefit to have the same resource be available to all facilities.

It is recommended that:

An employee assistance program be made available to all residential care facilities and be funded by the Department of Family Services.

It is also critical that regardless of the outcome, there be some follow-up with the child. This does not always occur. If the staff person does not return to the workplace, the response will be different than if he/she does. In the case of false or unfounded allegations, much work is needed to help the staff person re-integrate and work with the child.

Many recommendations above refer to specific issues which have an impact on staff morale. Of equal importance, however, is the organizational structure and philosophy of facilities, and how staff are treated by their employers.

In residential care, facilities differ dramatically in structure, setting, and the environment they create. They range from locked institutions to a truly "home" environment.

A wide range of philosophies and values also exists. Given the enormous changes which have occurred during the last decade in understanding abuse (particularly sexual) and treating victims of same, it is important that there be room for growth and difference in views. What is of

concern, however, is that there is a lack of consistency in basic attitudes and values towards children. Every facility somewhere or other uses the phrase "meeting childrens' needs". It appears that some pay little more than lip service to this notion and others are simply inept at it. There are facilities who have all the right intentions and others, all the right training and yet, somehow are not able to produce a safe, nurturing, supportive and caring environment for children.

Of significance to this issue is the structure of facilities. On the one hand, there are organizations that operate on the notion of the "inverted triangle". The most important people are the children and the least important is the director. Such organizations are open, and supportive of employees and children. There are no secrets. Line, supervisory and management staff are involved in decision making generally and concerning children's needs. Children are listened to. Internal and external relationships are positive, collaborative and supportive.

On the other hand, there are also very closed hierarchical organizations where line staff are disempowered, uninformed, and unsupported by management. Fearful of making mistakes, raising concerns, or reporting on other staff, they often feel barely able to maintain control of children.

Management functions without input from line workers. Supervisors and management are given opportunities and benefits that line staff are not. Morale is very poor and turnover is often high - both in terms of staff and children.

These organizational issues are both troublesome and difficult to address. Greater accountability through regular program review and evaluation, increasing and standardizing the level and quality of training and putting support resources in place for staff should go some distance to resolve these problems. Fundamentally, however, both facilities and the system must recognize that the only true safeguard in residential care is the people to whom children are entrusted. If those people are not valued and empowered their ability to help and protect children will be considerably reduced.

CHAPTER V

CHAPTER V - PERSONNEL PRACTICES

It is universally acknowledged that the key to achieving any measure of success in this system is the ability to develop trusting relationships with the children served. Although a simplistic statement, it is often a formidable task.

The unanimous opinion of those interviewed is that the needs of children in care have changed dramatically over the past ten years. The degree of dysfunction suffered by children is much greater and the incidence and effect of violence in their lives is considerable. Most of these children have very complex problems, often resulting from multiple forms of neglect and abuse.

The most valuable asset in any facility is the staff that work directly with children. This work is demanding and difficult and requires considerable skill and ability. It is also essential that youth care workers are emotionally healthy, mature, caring persons with a non-punitive view of helping children. A concern consistently expressed is that these critically important qualities are often lacking in staff.

In addition to these basic qualities, youth care workers must have a solid understanding of the needs and behaviors of children in their care. Knowledge of sexual, emotional, and physical abuse, emotional and physical neglect, adolescent sexuality and anger management are necessary. Non-violent crisis intervention and counselling skills are essential. Finally, the need for a clear understanding of the obligations and expectations placed on staff by The Child and Family Services Act, The Social Services Administration Act, Regulations and Standards is required.

Although often described as "reparenting", the work of youth care workers in many ways is better described as emotional nursing. Staff are expected to help children overcome the difficulties of their past and achieve some degree of healing. They are continually required to assess situations based on behaviors presented by children, and make judgments as to appropriate action and interventions. The skill and knowledge necessary to do this effectively cannot be underestimated.

The skills, abilities, and personal qualities of staff in residential facilities varies greatly. While many are highly skilled and knowledgeable, many are not. As a result it can and often does happen that some of the most

damaged children are being worked with by the least qualified individuals. This is not acceptable.

Consistency, both in the staff who work with children, and consistency in how children are treated by those staff is critical in residential care. Children interviewed expressed concern over both these issues. High rates of turnover in staff is a common problem in facilities. Staff often have differing attitudes, standards and expectations.

Facilities indicate that it is difficult to find qualified candidates to fill positions. As a result, they frequently must hire staff with limited relevant education, training or experience. This is particularly so in the case of casual or relief staff. This has a negative impact on both children and staff. As one worker commented, having a co-worker with little or no training and experience sometimes is not that different to having one more child to look after.

Salary levels are a major factor in the shortage of qualified staff. The demands and risks of the work are far greater than exist in many comparable positions which pay more. The survey conducted during the Review shows that starting salaries for youth care workers range from $8.20 to

$9.70 per hour for non-governmental facilities. Starting salaries at Provincial facilities are $12.57 per hour.

Although there have been increases in the per diem rates paid to facilities in recent years, there is still a discrepancy in starting salaries of $3.00 to $5.00 per hour, when compared to Provincial facilities. Steps should be immediately taken to address this.

It is recommended that:

The Department of Family Services implement a funding formula for residential care facilities to allow for parity with Provincial facilities.

A. **TRAINING**

The lack of accessible, relevant training is a matter of great concern in residential care. While there is a number of degree or certificate programs in Human Services available throughout the Province, most do not provide the knowledge base necessary to work with children in residential care. There are only three programs which provide relevant training. All have significant limitations. Red River Community College offers a two year certificate program on a part-time basis only. New Careers is an affirmative action program which runs a basic training and upgrading program intermittently. A pilot project of eight trainees was completed in 1991, and a second class of sixteen is currently

underway. The Continuing Education Division of the University of Manitoba also offers a certificate in Applied Counselling which is intended to upgrade the skills of persons employed in counselling related positions. Both Red River and New Careers require that applicants have a position to go to before they will be accepted into the program. This is obviously limiting. Concerns have also been expressed by many that the content of these programs needs to be reviewed, expanded and updated, particularly to include cross cultural training.

Thus, the burden of training staff usually falls on facilities themselves. The result is inevitable - some facilities achieve remarkable results and others fail miserably. Although limited training budgets have been funded for facilities, the lack of available relevant courses has resulted in a piecemeal approach to training, and inefficient use of those budgets. Added to this is the fact that staff are usually required to attend seminars and workshops on their own time because facilities cannot afford to pay replacement staff. This further limits availability.

The need to address training and qualifications of youth care workers is long overdue and should be addressed as a priority.

Establishing an accessible and relevant program of education/training for youth care workers is essential. This must happen with input from those in the field of residential care to ensure that any program is relevant and reflective of needs. It must also be accessible throughout the Province.

It is recommended that:

The Minister of Family Services establish a Curriculum Development Committee which includes representation from residential care facilities and youth care workers.

The Curriculum Development Committee work in conjunction with the Department of Education, community colleges, and other educational institutions to develop an appropriate educational training program for youth care workers.

Fundamental to ensuring consistency and quality in care is the setting of minimum qualifications for staff. While there should always be room for differing programs and philosophies, there are basic standards of care that should exist. By analogy, there are basic standards of care provided in hospitals, day care and school settings that are reasonably consistent regardless of the size or location of the facility. This can only be achieved by certification/classification of staff.

The benefits of a classification system similar to day care would be substantial. Since 1983, when the classi-

fication system was introduced in child day care, the improvements in the quality and consistency of programs throughout the Province have been enormous.

Regulations passed pursuant to The Community Child Day Care Standards Act contain licensing requirements which define the minimum standards for operation of day care centres, including supervision and training of personnel. The skills of child care workers are summarized in "child care competencies". These have been adopted by the Manitoba Department of Education and Training as the necessary minimum qualifications that child care workers must demonstrate when working in child care programs. Competencies are measured either by successfully completing an approved child care education program at a post-secondary educational institution or through Competency Based Assessments. Workers are classified as a Child Care Worker I, II or III, and regulation dictates the number of workers with each classification level that can be employed in a centre. A director of a centre must be a Child Care Worker III.

The need for a certification or classification system for youth care workers has been recognized by residential care for some time. A joint committee of the Child and Youth Care Workers Association of Manitoba and The Manitoba Association of Treatment Resources for Youth has

lobbied government for approximately ten years to implement a certification/classification program. The fact that successive administrations have failed to support such a program, particularly in light of the highly structured classification system in Child Day Care, is a cause for concern and cynicism among those involved in residential care.

It is recommended that:

Regulations be passed pursuant to The Child and Family Services Act, to set classification levels for youth care workers and minimum qualifications for each level.

Such regulations specify time periods within which all staff in facilities are to be classified, similar to those contained in The Community Child Day Care Standards Act.

The Curriculum Development Committee develop youth care competencies to establish a program of competency based assessments.

The regulations set forth the time periods during which all staff are to meet the minimum qualifications, and allow upgrading and competency based assessments to occur.

The Directorate establish a registry for youth care workers to monitor the progress of the classification process.

A classification program should also allow for tracking of workers as well as control and entry into the field. Law enforcement agencies express the concern that it is very easy for staff who are known or suspected offenders to move from facility to facility without detection. Day

Care regulations require that information concerning staff employed be provided to the Day Care Directorate.

It is recommended that:

All residential care facilities be required to provide the Directorate with a list of all staff and thereafter notify the Directorate of any changes in staff.

The introduction of a classification system will make the need for improved salaries that much greater. The difficulties in attracting qualified candidates for positions will only increase if workers are required to have completed an education program, but are not provided with a salary that recognizes those qualifications.

Classification is not an undertaking that can be completed in the short term. For example, the classification system in day care was implemented in 1983 and not completed until October 1991. In the meantime and as a priority, measures must be taken to improve the quality of training and education for staff in residential care. A series of core courses should be developed and introduced immediately. These courses should be incorporated into the classification system. To ensure that these courses are accessible and utilized by staff, it is essential that funding be provided.

It is recommended that:

The Curriculum Development Committee identify and develop a series of core courses for youth care workers, and such courses be immediately available for staff in residential care facilities.

The Directorate establish a fund to cover the costs of delivering these courses and replacement of staff.

A very significant factor in residential care and youth corrections facilities is the lack of recognition given to the cultural and linguistic needs of Aboriginal children in their care. It is essential that cross-cultural training be treated as a priority.

It is recommended that:

Training in Aboriginal cultural and linguistic issues be included in the core courses developed by the Curriculum Development Committee.

B. SUPERVISION

Quality supervision is a cornerstone of any successful organization. The stress and demands of working with children in residential care are enormous. There often is no "right" solution to problems or behaviors. The need for support, team building, leadership, and growth, in addition to developing good youth care skills is essential to ensure a healthy, competent work force.

It is a trite observation that the skills of a good line worker and that of a good supervisor are not the same. Unfortunately, it appears that many supervisors have only history to qualify them for their job.

The Child and Family Service Standards require facilities have a code of conduct, disciplinary policy, utilize annual performance appraisals, and orientation programs. These are all good supervisory tools. If used, they should assist in developing skills, setting expectations, and bringing consistency of care within a facility. However, it would appear that many facilities do not use or at least make effective use of these tools. It is questionable whether some supervisory staff have sufficient training and expertise to know how to do so.

Management of facilities often express the view that it is difficult to take action with respect to staff who are ineffective and inappropriate with children. No doubt this is so if there is nothing in place defining expectations. It is a considerable lapse on the part of employers not to ensure that expectations concerning employee conduct be clearly stated and enforced.

A Code of Conduct is a critically important document for youth corrections and residential care facilities.

Properly drawn and used, it can provide both guidance and a basis for sanctions. Section 473.11 of the Child and Family Services Standards requires that each facility have a Code of Conduct that addresses breaches of confidentiality, physically inappropriate behavior, breaches of agency policies and procedures, breaches of ethical conduct, as well as other issues. It fails to mention however, the basic notion of attitudes towards and treatment of children.

In addition the Standard contemplates (but does not require) that a facility have stated policies and procedures and standards of ethical conduct for its staff. Many do not. Further, only some facilities include, as part of their job description for staff, necessary personal attitudes and behaviors.

The Child and Youth Care Workers Association of Manitoba has developed a comprehensive Code of Ethics which some facilities utilize. Although not the only model, it does provide a useful example of expectations as to appropriate conduct and behavior.

Facilities have to be able and willing to use policies. During the Review, it was clear that there is sometimes a gap between the written philosophies and policies of facilities, and the reality they present. There were

instances where facilities had a set of comprehensive objectives, philosophies, and policies yet were full of negative control and questionable attitudes. This demonstrates, among other things, ineffective and poor supervision.

A classification system would have the capacity to address minimum qualifications for supervisory personnel. In the short term however, it is important that basic training for supervisors be a goal for the system. A basic supervisory training program should be developed, implemented and funded.

It is recommended that:

A comprehensive Code of Conduct be developed for all residential care and youth corrections facilities.

The Curriculum Development Committee develop a set of core courses for supervisory staff in residential care facilities.

Allegations of abuse raise (or potentially raise) protection issues, criminal law issues, standards/licensing issues and employment issues. Some facilities appear to be at a loss as to what to do if the police decide not to lay charges, and/or the agency concludes that the child is not in need of protection. Often there is little follow-up with the employee to determine whether the employee's conduct showed questionable judgment or was otherwise inappropriate. It is absolutely essential that this occur. Many allegations arise

as a result of questionable practices or actions on the part of the staff involved. Unless addressed, the potential for recurrence is considerable.

C. **STAFF MORALE**

In general, the residential care system is suffering from a crisis in morale. Although the public often perceives them as glorified babysitters, the demands of this work cannot be overstated. Rarely, however, are youth care workers given recognition. Placed in impossible situations, they are frequently blamed by families, agency workers, the Directorate and the media if something goes wrong. Their work is not valued in monetary terms. There is an increasing level of frustration with inadequate resources, and a deep fear that this problem will only worsen.

Staff often feel isolated and powerless. Many work in fear of being physically hurt or losing control of the children. With 8 (or 9 or 10) children in a facility, all of whom have complex needs, difficult and sometimes violent behaviors, the risk of losing control is often a part of the job for staff. Staffing levels are inadequate in many instances. Less frequently, but certainly not unusual for some facilities, is the risk of physical harm. Many facilities are single staffed for up to 120 hours every month. Working alone can be frightening.

Added to this is the spectre of false allegations which has had a paralyzing effect on many staff. This concern arises from the growing number of allegations against staff that are ultimately determined to be unsubstantiated. Compounding matters is the fact that investigations are often unpredictable, unfair, and biased. Vindication usually sought, rarely occurs as often the only reported conclusion is that the allegation was not proved. This invites speculation as to whether the person is guilty of what was alleged. Many feel that once accused, a cloud of suspicion follows a staff person for life, regardless of the outcome.

Unfortunately, there seems to be a tendency for many in the system to assume that any unproven allegation is borne of malice. It appears that these situations are in the minority. Research in this area indicates that only a small percentage of unfounded allegations are false.

Information available to the Review Team indicates that there are several common situations where allegations against staff occur. One is where a staff person physically restrains a child. Children interviewed say that restraints are very frightening to them, whether they are being restrained or witnessing another child being restrained. To many, it replicates the violence they experienced in family

settings. While restraints may be necessary in certain situations, they are often used as a convenient and crude form of control. Techniques employed are often questionable. Better training in non-violent crisis intervention and anger management is lacking on the part of many staff. There are more fundamental issues of power and control that can be a contributing factor and need to be addressed through training.

Another common situation is where a touch, look, or comment is interpreted by a child to be sexual when it is not intended to be. This may be a consequence of a child with a lifetime of sexual abuse, and simple ignorance on the part of staff as to how an abused child might interpret a situation. Lack of training in self-awareness and appropriate boundaries on the part of staff are also factors in many of these situations.

It is recommended that:

Non-violent crisis intervention and self awareness training be included in the core courses developed by the Curriculum Development Committee.

The most difficult of all situations is one where a child alleges that a worker "looks like" or "reminds me of" an abuser. Such allegations must be investigated to determine whether the person may, in fact, be one in the same. If

this is not so, considerable effort must be invested to ensure that the child feels safe. This may not require that the worker be removed from the workplace, although some safeguards may have to be put in place.

There will be times when it can only be concluded that a child's allegation of abuse was malicious and false. That children in this system might make false allegations should not be surprising. Society, and child welfare in particular, have gone to great lengths to give children permission to talk about abuse and to give the message that disclosures will be acted upon. Having been given a tool to empowerment, it is not surprising that these children might use that tool to hurt. No doubt, negative power is the only power many children in care witnessed in their family settings - or for that matter, while in care.

Where allegations are falsely made, staff must respond appropriately just as they would respond to any other form of hurtful behavior by children. Children must learn logical consequences of their behavior.

It is also essential that staff, both the accused and co-workers, have the opportunity to process and deal with false allegations once an investigation has been completed. False allegations typically cause great anxiety and dis-

ruption in facilities. Closure is necessary to minimize children's use of negative power and reduce the risk of staff becoming ineffective.

Staff must also increase their ability to deal with allegations. Improving the way in which investigations are conducted in residential care and young offenders facilities should reduce much of the fear of the process. In addition, many staff need a clearer understanding of how and why unfounded allegations arise and appropriate and effective ways to respond to them.

Many staff appear confused and uncertain as to what they can and cannot do. Repeatedly, the Review Team encountered experienced staff who now question their judgment and admit that the potential for an allegation of abuse is ever present. The impact that this has on a person's effectiveness is substantial.

Inherent to the process of teaching children to develop relationships with others is the notion of taking risks. If the message children receive is that their care givers and role models will not take risks, it is hard to imagine that they will do so either. Learning positive touch is crucial to children whose only experience of being touched by another human is in a hurtful way. Many staff indicate

that they will no longer take the risk of touching kids except where absolutely essential. A number of staff expressed the view that the risks of this work have become too great to continue to work in the area.

Staff in facilities need to know what situations can place them at risk of false allegations, and how to minimize those risks. A guide to safe practice would be an important and useful tool for youth care workers.

It is recommended that:

The Department of Family Services make available project funding to develop a safe practice manual for youth care workers.

These situations present tremendous challenges for those who work in residential care. Whatever the reasons, there can be no question that unfounded allegations are a risk of this work and the sooner and the clearer that message is given to all those who enter this field the better.

Orientation for new staff should address both the risks in this area, as well as the process for investigation of allegations.

It is recommended that:

All residential care and youth corrections facilities include as part of orientation for new staff, safe practice guidelines and procedures for investigating allegations of abuse against staff.

D. SCREENING PROCEDURES

Thorough, in-depth screening is critical to residential care and youth corrections facilities. The essential personal qualities necessary to be effective in this work cannot be measured either by good intentions or a certificate, degree or diploma. Pre-employment screening can go a long way to eliminate those who do not have these necessary qualities.

In addition, it is well recognized that certain sexual offenders, known as pedophiles, are attracted to work that allows them access to children. Many of these offenders are very adept at developing relationships with children. They are often difficult to detect and to the unskilled (and sometimes even the very skilled) interviewer, can appear to be ideally suited to working with children.

An understanding of both the causes of and what the risk indicators are and how they can be identified, is necessary in order to conduct an effective screening interview. As with other issues, information available to the Review

Team indicates that there is great diversity in the skill and knowledge of facilities in this area.

Further, many facilities appear to be under a misapprehension as to the provisions of The Human Rights Code. Concern was frequently expressed that questions concerning the personal values, history, family of origin or life experiences of job applicants would violate the Code.

A number of organizations, such as Big Brothers have developed comprehensive screening procedures for applicants that address many of these issues. There is a need for a standardized, comprehensive screening/interview procedure to be implemented throughout residential care. There are resources available within Manitoba, both in terms of individuals as well as organizations such as The Child Protection Centre, who have the necessary skill and expertise to develop such procedures and provide training in the proper utilization of same.

It is recommended that:

A standardized screening procedure for all residential care and youth corrections facilities be developed.

Any persons responsible for hiring in a residential care or youth corrections facility be trained in the use and implementation of such procedures.

Currently, the Standards require that facilities conduct criminal record and Child Abuse Registry searches, and check references, including an applicant's last employer. Results of the survey indicate that all facilities require personal and employment references. It is questionable as to the extent to which facilities make effective use of these. This can provide valuable insight into some of the essential personal attributes of potential employees.

It is recommended that:

All residential care and youth corrections facilities employ thorough reference checks in screening job applicants.

Criminal records and Child Abuse Registry checks are limited in value for a number of reasons. A Criminal Records Check will only indicate if a person has been convicted of a criminal offence and the nature of the offence. Given the conviction rate for offences where children are involved, this will be a very small percentage of persons who have offended.

The Child Abuse Registry has been plagued with controversy since its inception. Recent changes have been made to overcome Charter issues, although difficulties remain, both in scope and implementation.

Section 19(4) of the Act provides the circumstances where a person's name shall be reported for entry in the Registry:

19(4) An agency shall report to the Director for entry in the Registry maintained under section 19.1, the name of a person who has abused a child and the circumstances surrounding the abuse where;

(a) the person has been convicted by a court of abusing a child;

(b) the person has been found by a court in a proceeding under this Act to have abused a child; or

(c) the Child Abuse Committee is of the opinion that the person has abused a child.

The triggering event is abuse of a child, which by definition is limited to a person who is a parent, guardian or a person having care, custody, control or charge of a child. Third parties who cause a child to be in need of protection are not subject to placement on the Registry.

Section 19.3(2) and 19.3(3) state that one of the purposes of the Registry is to assist agencies or others who employ or otherwise involve persons in the care or access to children. The effectiveness of the Registry is limited by not including third party offenders.

The definition of "abuse" for purposes of the Registry should be broadened and include third party acts or omissions. Alternatively, and at a minimum, the approach taken by the Nova Scotia Children and Family Services Act should be adopted. Section 63 of the Act provides that a person convicted of an offence against a child is subject to placement on the Registry.

It is recommended that:

Amendments be made to The Child and Family Services Act to include third party assaults in the definition of abuse for purposes of the Child Abuse Registry; or

Section 19(4) of the Child and Family Services Act be amended to include persons convicted of criminal offences against children.

Another difficulty is that offences are often reported to the police directly without the involvement of an agency. In this case, if no conviction is registered, the matter will not come before an agency abuse committee for consideration.

Section 18.4(4) of the Act requires that where a peace officer charges a person with an offence under The Criminal Code or under the Act and the offence is based on alleged acts or omissions by the accused in relation to a child, the peace officer is obliged to advise the employer of

the accused if the person's employment involves the care, custody, control or charge of children or permits unsupervised access to children. There is no requirement that the peace officer advise an agency or the Director. Such a requirement would add to the effectiveness of the Registry process.

It is recommended that:

The Child and Family Services Act be amended to provide that agencies or the Director be notified when a person is charged with an offence based on alleged acts or omissions by that person in relation to a child.

A procedural matter that impedes the Registry's effectiveness is the difficulty in obtaining confirmation of a conviction. At a minimum, the accused's birth date is required and this is often not available. Registry officials indicate that they have been attempting to establish some system of automatic notification of convictions by the Department of Justice. However, they have been unsuccessful in negotiating such an arrangement with Department of Justice officials. This should be addressed.

It is recommended that:

The Department of Family Services and the Department of Justice develop and implement a process whereby relevant convic-

tions are automatically referred to the Child Abuse Registry.

A host of other issues with respect to the Child Abuse Registry exist. These include questions such as the need for a registry for victims, the backlog of cases before the regional abuse committees, and inconsistent standards among the various agency committees. These issues should be addressed to improve the effectiveness of the registry for employers.

CHAPTER VI

CHAPTER VI - ENSURING COMPLIANCE

Given the vulnerability of the children it serves, the residential care system cannot depend on the beneficence of those involved to ensure compliance with standards and expectations. In theory, there are many layers of accountability that exist in the system. The extent to which they are effective is somewhat questionable.

A. CHILDREN AND THEIR RIGHTS

The first step in reporting any incident of alleged or suspected abuse is learning that the behavior has occurred. As discussed previously, in many, if not most instances, unless a child tells, it may be that no one will ever know abuse has taken place. Children in care must feel and know they are safe in order to disclose incidents of abuse. It is equally important that they be aware of their rights, be given opportunities to exercise those rights and be supported in doing so.

Information from current and former residents of the residential care system suggests that some children are very aware of their legal rights and how to act on them. Others have limited knowledge of their rights and some are not aware that they have rights at all.

Under The Child and Family Services Act, children in care have rights beyond the basic right of all children in society to be protected from abuse and neglect. The following rights are enumerated in the Preamble to The Act.

> "6. Families and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.
>
> 8. Families are entitled to services which respect their cultural and linguistic heritage.
>
> 9. Decisions to remove or place children should be based on the best interests of the child and not on the basis of the family's financial status.
>
> 11. Indian bands are entitled to the provision of child and family services in a manner which respects their unique status as aboriginal peoples."

Section III of the Act gives children the right to be present at a hearing (if aged 12 and over), the right to copies of documents during legal proceedings and the right to instruct legal counsel. The Act also provides children with the right to appeal any decision to an agency and then to the Director.

In Part IV of the Child and Family Services Standards children have the right to:

> "be informed of their rights, have their opinions heard and be included in any decisions affecting their life; freedom from physical, emotional, and sexual abuse; decisions made in their own best interests; and, access to Manitoba's available services and resources free from discrimination based on race, religion, and ethnic origin and which respect their cultural and linguistic heritage."

Part IV also stipulates that a child is entitled to regular contact with his or her worker, involvement with family and freedom from unnecessary or inappropriate restraint, discipline, isolation or treatment. While facilities are required to establish an internal grievance policy, the Standards do not state what this policy should include, or require that it be posted.

Results of the survey conducted during the Review indicate that approximately half of the facilities have a policy which deals with children's rights. These policies vary from a list of House Rules to a list of rights similar to that contained in the Standards. Inconsistency in form and content prevailed.

Most facilities have a policy in place for lodging complaints and grievances. These tend to focus on the internal processes of the facility and generally make no reference to external sources of appeal. None of the policies reviewed

state that a child has the right to appeal to the Director. Grievance policies should reference the entire process available pursuant to the Act.

Having a written policy in place does not ensure that children will be aware of their rights. Interviews conducted raised questions of how thoroughly rights are being explained to children.

When children do receive information of their rights, this usually occurs as part of an orientation to the facility. Few facilities appear to re-inform children of their rights thereafter. A recent study in Ontario suggests providing such information on entry to a placement is usually too early for any significant level of retention to occur. The study recommended children in care be informed of their rights every six months.

Equally as important is the accessibility of information to reinforce what children have been told. Posting of information other than a licence is not the norm in residential facilities. This is not surprising given that the Standards only require the licence be displayed. Posting rights and entitlements, employee codes of conduct and griev-

ance policies would help ensure that children become aware of their rights and know what to expect while in care.

It is evident that there is no consistent approach used by residential facilities or agency workers to inform children of their rights and entitlements. There is no explicit requirement in the Standards that children be informed of their rights. It is not enough to rely on the initial orientation that children may receive when being placed in a facility.

It is recommended that:

The Child and Family Services Standards require children be informed of their rights and entitlements prior to, or upon entering a residential care facility.

The Child and Family Services Standards require children be re-informed of their rights and entitlements at least every six months while in care.

The Child and Family Services Standards require all residential care facilities to have a grievance procedure which fully explains all avenues of appeal available to children under the Act.

All residential care facilities be required to display, in a conspicuous location, children's rights and entitlements, employee codes of conduct, and grievance or complaint procedures.

The Child and Family Services Standards require that, upon placement, the child be advised of the grievance and complaint procedure both internal and external to the facility.

The Standards also contain a section on "parents/guardians rights" when their child is in care. This includes (unless the child is a permanent ward): involvement in making plans for their child, to be consulted on any changes to the plan, to visit their child, appeal any decision of the worker, receive assistance in resolving family problems, and, attend any court hearing affecting the child. Where a child is a permanent ward involvement with the family is subject to review by the worker.

The Preamble to the Act recognizes the important role of the family as the basic unit of society with the primary responsibility for the care and nurturing of children. While it may be implicit that workers are to inform parents or guardians of their rights under the Act, this is not required by the Standards.

It is recommended that:

The Child and Family Services Standards explicitly require that parents and guardians be informed of their rights and the rights of their children.

The rights of children in custody are enumerated in Section 3 of The Young Offender's Act. These rights cover a variety of areas. Included is the right to the least possible interference, the right to be heard, the right to participate in decision making, the right to be informed of

their rights, as well as the recognition of the importance of the child's parents in having responsibility for the care and supervision of children. Young offenders also have entitlements concerning proceedings, the right to retain/instruct counsel, access to records, and disposition reviews.

The Act includes in its "Declaration of Principles" reference to the fact that "young persons have rights and freedoms in their own right, including those stated in the Canadian Charter of Rights and Freedoms or in the Canadian Bill of Rights". There is no requirement under the Act that a child be informed of his or her rights while in a custody setting. Under The Juvenile Delinquents Act this was the responsibility of the youth's Probation Officer. The young offenders facilities each provide an orientation outlining rules, privileges and sanctions for children in their custody. They indicate that children are usually informed on entry that they have the right to a lawyer, the right to a review, the right to contact with their lawyer and family, and the right to have input into case planning. Written material outlining their rights is not provided. Posters advertising the availability of the Ombudsman to children in custody are displayed.

It is recommended that:

Youth correctional facilities be required to inform children in custody of their rights under The Young Offenders Act and their rights specific to the facility in which they are placed while in custody.

Youth correctional facilities be required to inform the child's parents or guardians of their child's rights as well as their parental/guardian rights related to their child being in custody.

Youth correctional facilities be required to inform children of the grievance/complaint procedures applicable to the facility within which they are placed as well as those avenues available to them which are external to the facility in which they are placed.

Youth correctional facilities be required to post grievance/complaint procedures, employee codes of conduct, and children's rights while in custody in conspicuous locations throughout.

A child in custody be re-informed of his or her rights at regular intervals while in custody.

No discussion of children's rights is complete without acknowledging the United Nations Convention on the Rights of the Child or the Canadian Charter of Rights and Freedoms. Canada became a signatory to the Convention in the Fall of 1991. While the Convention does not automatically apply to Provinces it is important to this discussion as it sets out specific rights that apply to children.

There are 54 Articles to the Convention. Many relate to children in care or custody. The Convention has been some time in the making and it is presumed the Province

is well aware of its contents, however, it is important to ensure that Provincial regulations and standards are consistent with it.

It is recommended that:

The Departments of Family Services and Justice review all applicable legislation, regulations standards and guidelines with respect to children in care or custody in light of the provisions contained in the U.N. Convention on the Rights of the Child to ensure consistency.

It is noteworthy that The Young Offender's Act refers to the fundamental freedoms guaranteed under the Canadian Charter of Rights and Freedoms while The Child and Family Services Act does not. One could loosely interpret the "Principles" stated at the beginning of The Child and Family Services Act as being in keeping with the Charter. An explicit reference in the Act to the rights children have under the Charter would give recognition to their fundamental rights as citizens.

It is recommended that:

The Child and Family Services Act, Regulations and Standards be reviewed to ensure consistency with the Canadian Charter of Rights and Freedoms.

Reference be made to the Canadian Charter of Rights and Freedoms with respect to children in care under The Child and Family Services Act, Regulations and Standards.

B. **LOCKED SETTINGS**

A matter of concern is the use of locked settings for children in care. There will be circumstances where it is in a child's best interests to be placed in a locked facility and there will be situations where the use of a locked room can be justified. The absence of a legislated base setting out the circumstances under which such settings may be used results in a lack of adequate safeguards against indiscriminate use.

It is important that regulations be established to, at minimum, set admission criteria, maximum length of time and minimum expectations for monitoring children when a locked setting is used. The regulations should cover both placement in a locked facility and the use of a locked room within a facility.

The Child and Family Services Act is silent on the use of locked settings. There are a number of locked residential facilities in Manitoba. The Standards do not address placement in such facilities. The use of a locked room within a facility is allowed by the Standards where it is for the safety of the child and no other alternative is viable. Ontario has specific provisions in its legislation outlining the conditions under which locked rooms are to be used. The

Director must approve the setting and criteria for its use. A one hour maximum is prescribed and the child must be continually observed.

Basing these conditions in legislation creates stronger safeguards against misuse. While there is no specific evidence to suggest that locked rooms are being misused, a general concern arises about the appropriateness of what may be considered "unlawful confinement." Certainly children in residential care often exhibit extreme behaviors, but the use of locked rooms to control behaviors should be regulated and kept to a minimum, as should placement in locked facilities.

It is recommended that:

Regulations be passed pursuant to The Child and Family Services Act establishing criteria for the admission, length of stay and review of placement in locked facilities; and the approval and use of a locked room within residential facilities.

A separate issue concerns the use of unlocked rooms for the purposes of confinement for disciplinary reasons. Section 457 of the Child and Family Services Standards acknowledges that temporary removal from a situation is an acceptable disciplinary method whereas prolonged confinement to bed is prohibited. Residential Care Licensing Standards also provide that confinement of residents against their will

and actions which are contrary to a resident's care plan are not to occur.

Information available to the Review Team suggests that some facilities use confinement too often, inappropriately and for excessive periods of time. This may constitute a form of abuse.

There are no standards which set out the conditions under which confinement of a child to an unlocked room is to be used or for how long. This is a serious gap in the program standards for residential care facilities. Standards, similar to those recommended for the use of locked settings should be established to control the use of confinement as a behaviour modification tool.

It is recommended that:

Standards be developed establishing criteria for the use of confinement to an unlocked room as a disciplinary method and that such standards require the child's worker to be notified each time an unlocked room is used for confinement.

In a previous section of this report it was recommended that a manual of safe practice be developed which would apply to residential care workers. Instituting such a policy along with measures to inform children and their parents/guardians of their rights and legislation to control

the use of locked settings and other forms of confinement will serve to reduce the unnecessary utilization of practices which may be in violation of basic human rights.

C. CHILDREN'S ADVOCATE

The Province recently announced that an Office of the Children's Advocate will be established in Manitoba. Both the Kimelman Report (1983) and the Aboriginal Justice Inquiry recommended that the Province establish such a resource reporting directly to the Legislature in a similar fashion to the Ombudsman.

Parents or other family members are considered to be natural advocates for children. Parents can no longer fulfill this function when, due to abuse or neglect, the child must be taken into care and the State becomes the child's legal guardian. The Child and Family Services Standards state that the agency worker is to be the advocate for a child in care. It is becoming widely recognized, however, that child welfare professionals cannot perform an independent advocacy role due to their vested interest in the service system. Pure advocacy can only be performed by a person who is objective and external to the service system.

The need for a separate advocacy function for children in care has been recognized in other jurisdictions.

Children's Advocates Offices exist in Alberta and Ontario with the mandate to ensure the rights of children in care are respected at all times. In Alberta, the Advocate is involved in three types of advocacy activities. Individual advocacy is done on a case specific basis to ensure that a child's interests and viewpoints are being considered in case planning. Class advocacy is done on behalf of a group of children in care who share a common problem with the service system. For example, this could involve advocacy on behalf of all children in a particular residential facility. The Alberta Advocate is also involved in "systemic advocacy" intended to ensure that standards and procedures meet the needs of children.

In Manitoba, with the exception of the Ombudsman whose mandate is limited to government facilities, there is no source external to the child and family service system where a child can lodge a complaint. The Act and Standards require that any appeals go through an agency and then to the Director. Many children indicated that if their rights were violated by a residential care facility, they would be reluctant to raise concerns with the same worker who arranged for the placement. For these children, no external source is available to protect their rights.

There is a pressing need for a Children's Advocate in Manitoba. The nature of any child welfare system is such that an external means to ensure accountability will always be necessary. The extent of the need in Manitoba is a reflection of how frequently the system fails children.

If the Advocate is to be effective in protecting children's rights, it is important that the office be completely external to the child and family service system and that the mandate include individual and systemic advocacy.

It is recommended that:

The Children's Advocate report directly to the Legislature as recommended in the report of the Aboriginal Justice Inquiry.

The mandate of the Children's Advocate include individual and systemic advocacy.

The notion of a children's advocate was almost universally supported by all those interviewed. To be effective, the Advocate must be known and accessible to children in care. Alberta has prepared an information package on their Advocate's Office that is given to children when they come into care.

It is recommended that:

An information package on the Children's Advocate be given and explained to children

when they come into care.

All residential care and young offenders facilities be required to post, in a conspicuous location, an information sheet on the Children's Advocate.

The information package and information sheet use language and be designed in a manner that is appropriate for children.

D. BOARD OF DIRECTORS

Residential care facilities are a loose collection of organizations with varying histories and structures. Many were started as charitable or benevolent organizations that, over time, became recipients of government funding.

There are no regulations or standards dictating the type of organization that may obtain a licence under The Child and Family Services Act, or The Social Services Administration Act. As a result, structures vary. Non-profit corporations, privately held corporations, individual operators, charitable religious organizations, and government run facilities all exist within the system. Some have a board of directors and others an advisory board. A few have neither.

Whether residential care facilities should be run on a for profit basis is a philosophical issue that need not be addressed. What is important, however, is that there be

as many layers of accountability as is reasonably practicable.

Internal to a facility but external to the day to day operations, a well informed Board can provide an important set of checks and balances. Further, inappropriate practices can arise at line, supervisory, and/or management level. While management should be able to respond and correct situations at the first two levels, where the problem is management itself, the role of the Board of Directors is critical.

Regulations passed pursuant to The Community Child Day Care Standards Act provide that any centre eligible to receive a grant must be operated by either an incorporated organization with an elected Board of Directors, or in the case of social, health, or community service agencies, a Management Committee responsible for the operation of the centre. The Board or Management Committee must consist of a minimum of five persons, none of whom is a member of the immediate family of an employee of the day care centre, a minimum of 20% of whom are parents or guardians, and not more than 20% who are employees of the day care.

Similar regulations should exist for any child care facility licensed under The Child and Family Services Act.

It is recommended that:

Regulations be passed pursuant to The Child and Family Service Act requiring that all residential care facilities be operated by an incorporated organization with an elected Board of Directors, or in the case of social, charitable or community service agencies, a Management Committee consisting of a minimum of five persons, none of whom are members of the immediate family of an employee, and not more than 20% of whom are employees of the facility.

Information available to the Review Team indicates that facilities who do have boards tend to recruit directors from the community at large, often with different skills and expertise. The degree of knowledge and understanding of programs, the role of the Directorate or agencies, or other matters including reporting requirements, varies among board members interviewed and is often a reflection of the person's background. Depending on the type and size of the facility, it may take several years before a board member has a thorough appreciation of these matters. In addition, as with many volunteer organizations, boards usually see a facility through the eyes of the Executive Director.

While volunteers cannot be expected to have the time available to understand all aspects of both the facility and the residential care system, it is important that they be aware of the essential obligations of facilities.

A useful orientation handbook has been prepared by the Day Care Directorate for persons who sit on Day Care Boards or Management Committees. Basic information concerning the role of the board, the functions of various offices, and evaluation methods is provided. A handbook setting forth similar information including the structure of the system, the reporting requirements of the Act and some of the essential standards would be of assistance to board/committee members of facilities.

It is recommended that:

The Directorate publish an orientation handbook for Boards of Directors and Management Committees of residential care facilities.

It is important that there be communication within the system at every level. An annual orientation meeting for boards, as well as one meeting per year between representatives of each board and Directorate staff should take place. These should assist greatly in the flow of information and enhance understanding of the system by those who sit on Boards.

It is recommended that:

The Directorate sponsor an annual orientation meeting for all persons who are serving as directors or members of management committees of residential care facilities.

It is also important that line staff have representation on the Board. In addition, line staff should have an opportunity to meet as a group with representatives of the Board/Committee in the absence of management and executive members. Some facilities have a Personnel Committee that performs this function.

It is recommended that:

All residential care facilities ensure that line staff are represented on the Board or Management Committee.

All residential care facilities establish a Personnel Committee whose functions include meeting with line employees at least once annually.

Section 454 of the Child and Family Services Standards requires that every facility have a grievance procedure for children in its care. It is important that such a procedure require the board/management committee of the facility to receive a copy of such grievances.

It is recommended that:

The Child and Family Services Standards require that all residential care facilities have a grievance procedure which requires a copy or notice of any grievance filed by a child be provided to the Board of Directors/Management Committee.

E. PLACING AGENCIES

Pursuant to the Act either the Director or an agency is the legal guardian of a child taken into care. Section 48 provides that the Director or agency shall:

(a) have the care and control of the child;

(b) be responsible for the maintenance and education of the child;

(c) act for and on behalf of the child; and

(d) appear in any court to prosecute or defend any action or proceeding in which the child's status is or may be affected.

The Child and Family Services Standards outline the duties and responsibilities of placing agencies with respect to children in care. The assigned worker is the child's case manager and is responsible for all significant decisions concerning the child.

The worker assesses a child's needs, arranges placement in a facility and thereafter is required to maintain regular contact with the child and the facility. In

long term placements, contact is to occur at least once per month. Quarterly case conferences attended by the child, facility staff and worker, are held at the facility. The worker is also responsible for any placement changes including discharge planning.

The Standards state that the onus is on the worker to ensure that the rights of the child are protected and that care and supervision are appropriate while in placement. Matters such as health and personal care, nutritional needs, clothing, community involvement, daily routines, education and employment, are all matters which the agency worker is to supervise, monitor and review.

Through their monitoring and contact with the child and facility, workers provide a layer of accountability and an important safeguard for children in residential care facilities. The worker is a potential recipient of disclosures should abuse occur and is intended to be a resource for a child who may be experiencing problems. Either through the child or as a result of direct observation the worker is in a position to know of any violations of the Act or standards. According to standards, such information is to be passed on to Residential Care Licensing.

To fulfill these functions a worker must have the time to maintain regular contact and develop a relationship with the child, have some knowledge of the facility and its program, and be aware of the standards. The extent to which this occurs varies greatly. A common concern expressed by facilities and children is that workers often have little contact with them. Residential Care Licensing rarely receives information from workers. There are several reasons for this. Many workers seem to know little about the facilities or the applicable standards. For example, most workers interviewed were not aware that facilities are required to have an internal grievance procedure for children. Often the only information workers have concerning facilities is anecdotal in nature.

A resource manual issued by the Directorate provides information concerning programs and admission criteria for all placement resources in the Province. Although the manual provides general information about facilities, it is of limited value. It is purely descriptive and does not provide enough detail on programs.

The majority of residential care resources are located in Winnipeg. Due to the lack of residential alternatives in northern and rural Manitoba, frequently workers must place children in Winnipeg. For these children, the

nature and extent of contact with placing workers is quite limited.

Caseloads assigned to workers are usually far in excess of the benchmarks established for setting agency funding levels. Protection issues must be a priority for workers. The volume of these is such that workers often have difficulty maintaining the level of contact required. Visiting with a child in a facility who is believed to be safe can easily be less of a priority than other more urgent matters.

The level of training and supervision workers receive is also a factor. The extent to which agencies expect workers to comply with standards is questionable. Generally workers and supervisors are unfamiliar with many provisions of the standards. This is a concern considering that agencies are responsible for ensuring the quality of care for children and is compounded by the fact the Directorate does not appear able or willing to ensure that agencies are complying with standards.

It is recommended that:

Agencies ensure that workers receive training in standards related to residential care facilities.

The Directorate take steps to ensure that all

agencies are complying with Child and Family Service Standards.

F. THE DIRECTOR OF CHILD AND FAMILY SERVICES

The child and family services system is administered by a Director appointed pursuant to the Act. In addition to the general responsibility of enforcing the Act, the Director is to:

- protect children;
- advise the Minister of Family Services and agencies on child and family service matters;
- develop standards and procedures for the delivery of child and family services;
- ensure agencies adhere to the standards and procedures;
- receive complaints;
- exercise the duty of an agency where no agency exists;
- supervise or direct the supervision of children in care;
- ensure the development of appropriate placement resources for children;
- prepare an annual budget and keep financial records related to child and family services.

The Office of the Director (The Directorate) employs approximately 50 staff. Generally, the mandate of the Directorate is to provide program and operational support to child and family service agencies, regional offices, foster care, residential care and other external agencies. Org-

anizationally, the Directorate is structured into three main areas, each managed by a senior administrator.

The Finance and Administration component is responsible for budget preparation, financial analysis and funding policies.

The Program Development and Review component is responsible for a variety of analytical, evaluation and monitoring functions. This includes establishing standards for service delivery, quality assurance, program audits, review of legislation and policy analysis. This component is also responsible for implementing the child and family service information system, developing a training program for field staff and representing the Directorate on various committees and councils.

The Programs component is intended to provide consultation and advice on all aspects of child and family services. Staff specialize in certain areas such as child abuse, family support, residential care or adoption. Interprovincial and international liaison is done through this section. Certain staff hear complaints/appeals, review incident reports and conduct case specific investigations as required. The child abuse and adoption registries are housed here. Other responsibilities include research and develop-

ment of new service proposals, post-adoption services and co-ordination of various inter-disciplinary committees. The Seven Oaks Youth Centre also reports to the senior administrator of this component.

Staff in all three components are involved in a variety of administrative and support functions such as preparing briefing notes, advising senior Departmental Officials, writing submissions and liaising with service providers.

During the course of this review, the Review Team was made aware of a number of issues pertaining to the role and function of the Directorate. These are discussed below.

1. Communication of Mandate

The role and function of the Directorate is not well understood throughout the system. This is particularly true for residential care providers. While many of those interviewed were familiar with particular individuals, few were aware of the scope of the Directorate's authority and activities.

Part of the problem rests with the lack of consistency demonstrated by the Directorate. When an issue is raised with the Directorate, the level of staff involvement

varies and responses may differ in similar situations. For example, in some instances the Directorate takes the lead role in an investigation and in other similar situations, has little involvement. This creates confusion for facilities and agency workers.

A common criticism by facilities and workers is that they only hear from the Directorate in times of crisis. When advice is sought, often the responses are not helpful. This contributes to a feeling of isolation and animosity.

2. **Monitoring and Evaluation**

An overriding responsibility of the Director is to ensure accountability. The Director has the legal obligation to ensure children taken into care are placed in an appropriate and safe environment. Setting and monitoring service standards is crucial to fulfilling this responsibility.

The Directorate has developed a comprehensive set of service standards for all areas of child and family services. Unfortunately, the standards are not well understood by agency workers or residential care providers. In some cases, there is only a single manual available to a large number of workers. Some residential care providers have never seen the standards that apply to them. Standards are

ineffective if they are not understood and enforced. This a critical failing of the present system.

The Directorate does not conduct regular standards reviews or program evaluations of residential care facilities. For the most part, the Directorate relies on the licensing reviews done by Residential Care Licensing. Accountability is severely compromised as a result of the Directorate's "hands off" approach. The Directorate has not played the leadership role needed to adequately monitor the child and family service system.

Responding to crises is not sufficient. The Directorate needs to establish a presence in the residential care system and build solid working relationships with service providers.

Most residential providers are generally familiar with the licensing criteria in Regulation 484/88R, and the Residential Care Licensing Standards. Staff from Residential Care Licensing Branch visit each facility twice a year to conduct licensing reviews. The visits are scheduled in advance and generally take about one day to complete. Reviews focus on the physical condition of the facility and basic care being provided to residents. Incident reporting is assessed in the same general way as any other standards.

While this provides some level of accountability, reviews of a more comprehensive nature are needed.

If the system is to improve safeguards for children, and ensure that placements are appropriate, accountability mechanisms must be strengthened. Service standard reviews and outcome evaluations should be regularly undertaken to determine whether the residential care system is protecting children and meeting their needs.

It was recommended earlier that regulations for licensing residential care facilities be established pursuant to The Child and Family Services Act, and that responsibility for licensing and monitoring of standards should be within the jurisdiction of the Director.

The monitoring done in Child Day Care provides a good model for accountability. The Day Care Directorate employs specialized co-ordinators who are assigned to a set number of day care centres. They visit the centres unannounced as part of regular licensing reviews, and spend time observing children, programs, and interactions between staff and children. The co-ordinators can recommend that a licence be cancelled or that a conditional licence be issued where the centre is given a certain amount of time to comply with

standards. The centres know who their co-ordinator is and the co-ordinator serves as a primary contact point.

Accountability in the residential care system could be greatly improved by establishing a similar type of monitoring function in the Directorate. Staff could be designated as "residential care co-ordinators" with similar functions to the co-ordinators in Daycare. Each co-ordinator would be responsible for licensing and assessing standards in a defined number of residential care facilities.

Licensing and standards reviews should be done twice a year and include an examination of facility records (files, client logs, personnel policies, financial records, etc.), observations of the children in the facility, interviews with staff, interviews with children, and an examination of all incidents that have occurred between reviews. The visits should be unannounced so that the co-ordinators can conduct their assessment within the natural environment of the facility. After each review the co-ordinator would produce a report to be shared with the facility.

Regular monitoring would significantly reduce the chances that violations of the mandatory reporting requirements could go undetected. This would put in place a formal mechanism whereby the relevance of the standards could be

tested. The Directorate and facilities could jointly determine if existing standards are outdated or new standards are needed. Co-ordinators would become a central contact point for facilities and could interpret Directorate policy and provide advice. Through this process, facilities would gain a better understanding of the role and service expectations of the Directorate. Improved communication of this sort is badly needed in the current system.

Based on the co-ordinator per centre ratio in Day Care, the twice annual reviews could be done by three or four staff members provided this was their main function. This is a minor investment given the benefits that would accrue to children in care.

It is recommended that:

Three staff be assigned by the Directorate as Residential Care Co-ordinators with the responsibility for conducting licensing and standards reviews similar to what is done in Day Care.

Residential Care Co-ordinators each be assigned responsibilities for licensing and assessing standards in a set number of facilities.

Procedures for conducting the reviews be developed and provided to residential care providers which clearly outline the purpose of the reviews, the process to be followed, and the role of the Directorate and facility staff.

A report be produced at the end of each review that is shared with the facility.

It would also be useful if the Directorate prepared a summary of all reviews done each year. This would be a type of annual "report card" giving a system-wide assessment of residential care. This report would assist in planning and would be a beneficial source of feedback for operators and mandated agencies. A copy of the report should also be given to the Children's Advocate and the Ombudsman given the "watchdog" role that each plays in the system.

It is recommended that:

The Directorate prepare an annual report on all licencing and standards reviews done at residential care facilities.

A copy of the annual report be given to all children's residential care facilities, mandated agencies, regional offices, the Children's Advocate, the Chief Medical Examiner and the Ombudsman.

The system needs to be able to evaluate the longer term effects residential care has on the lives of children. This can only be done through comprehensive program evaluations where goals are formalized and assessed through the use of outcome measures. Desired outcomes need to be clearly articulated so that through the evaluation process, different models of residential care can be compared and the appropriateness of treatment programs determined.

The use of "peer reviews" where representatives from different areas of the system are involved in the evaluation process is an appropriate model for this system. A team could be comprised of a staff person from the Directorate, a worker from an agency , and one or two representatives from residential care. In conjunction with the facility, the team could identify program goals, develop outcome measures, conduct the study and write the report to be shared with the facility. A different team could be used for each study thereby allowing for a large number of facilities to be involved. Each review would help facilities to make program changes that better meet the longer term needs of children. In addition, those who participated on the team would return to their own jobs with valuable experience and findings that may help improve programs in other facilities.

The Directorate should take a lead role in designing a standard model for these peer reviews and establishing a cyclical schedule where all residential care facilities would be evaluated at least every three to five years. The standard framework could be adapted to apply to any type of residential care facility. Directorate staff should also chair each evaluation team. This would ensure a consistent approach and allow for a comparison of results.

It is recommended that:

The Directorate take a lead role in designing a model for conducting outcome evaluations in residential care facilities.

A schedule be developed where each residential care facility is evaluated every three to five years.

The evaluations be done by teams using a peer review approach.

Funding be made available to allow agency workers and staff from residential care to participate on the peer reviews.

3. Role Conflict

The Directorate has a direct service delivery component in that it is responsible for Seven Oaks Youth Centre. This creates a conflict of interest and makes it impossible for the Director to objectively monitor the facility.

4. Overlap with New Winnipeg Agency

There is some confusion between the role of the Directorate and that of the new Winnipeg Child and Family Service Agency with respect to monitoring service delivery. The agency's perception of its mandate appears to duplicate the monitoring function of the Directorate. It is important that the two agree on a statement which explains the accountability function that each performs. Communicating this role statement to agency workers and residential care facilities will help to reduce some of the confusion.

5. Lack of Follow-Up

A matter of some concern is the failure of the Directorate to adequately follow through when problems have been brought to its attention. The Director has broad powers to ensure compliance with the Act, regulations and standards but in many instances appears unwilling to exercise this authority. The Review Team was made aware of a number of situations where deficiencies were identified but little was done by the Directorate to ensure remedial action was taken. The purpose of accountability is to effect positive change in the system. Problems must therefore be both identified and resolved.

CHAPTER VII

CHAPTER VII - SYSTEM ISSUES

The Review focussed on issues related to reporting practices in residential care facilities. It must be recognized that such practices do not occur in isolation and are affected by a larger more complex service system. There are many systemic issues that have a significant impact on the overall operation of facilities, including the likelihood that proper reporting will occur. The Review would be incomplete without identifying some of these broader issues.

A. PLACEMENTS

A variety of issues contribute to placements that are not appropriate. Some of these situations are preventable; others are not. All have an impact on the ability of a facility to properly care for a child and reduce the likelihood that staff will be in a position to learn of abuse that might be occurring.

1. Classification and Assessment

As outlined in Chapter II, both children and facilities are classified as Level II to V. These categories are intended to place children with similar needs together in a facility that can meet those needs. There are fundamental flaws with this approach, both in theory and practice.

Classifying children into four generalized groups is too simplistic, given the very diverse and complex needs of children in care today. In addition, the levelling system only reflects staffing ratios. The assumption that children with increasing needs and more difficult behaviors can be adequately cared for simply by increasing the number of staff is unsound. The expertise of staff is a critical factor, particularly for those facilities who work with the most damaged children.

Child and Family Services Standards require that a worker conduct a pre-placement assessment of a child. Based on this assessment the worker is expected to locate an appropriate placement.

There are several issues relating to assessments. The first is that assessment skills of agency workers are frequently inadequate. Lack of training of agency workers was commented on by the Reid/Sigurdson Review in 1987. Since that time, the Department has attempted to address this issue by developing a training function in the Directorate. Access to such training is inconsistent and overall, inadequate.

The recent introduction of the Reid/Sigurdson Risk Assessment model is an important and significant step in ad-

dressing this long standing problem. Training in the implementation of the model is critical and should be considered a priority.

An additional factor is the crisis environment in which placement referrals often occur. Workers frequently have to find placements for children quickly and under the pressure of many other urgent matters. In such circumstances, it is difficult to conduct a thorough assessment.

The vague classifications of facilities and children, combined with the environment in which referrals are made, result in lack of consistency in placements. Workers acknowledge that it is not uncommon for a child who is assessed by his/her worker as a Level IV, to end up in a Level III or even Level II facility, if it happens that the only available bed is in that facility. The result of course, is that children are placed in facilities that cannot adequately meet their needs and with other children with whom they should not be placed.

In addition, workers sometimes have little information concerning a child. This can be a reflection of the worker's skills or the time they are able to devote to gathering information. This is affected by the unacceptable state of information management in the system. Child and

Family Services does not yet have a computerized management information system. Given the importance of information gathering and sharing this must occur.

Even where workers have good assessment skills and sufficient information concerning a child, many children have such complex needs that a proper assessment cannot be done due to the limited time and resources available. There is an overwhelming need for a resource where children could be placed for two to six weeks and have highly skilled staff and clinical support to provide in-depth assessments and planning. Given their clinical expertise it may be appropriate for treatment centres to take on this function.

In theory, the Child and Family Services Standards provide some safeguards against inadequate assessments and inappropriate referrals. The Standards require that the worker's supervisor be consulted, and must approve every placement. Recommendations for placements are to be screened within the agency. The extent to which these occur is questionable.

In addition, the Secure Admissions and Placement Panel is responsible for approving all Level IV and V placements. The panel is appointed by the Director and consists of representatives of residential care facilities, child

caring agencies, mental health, and Seven Oaks. The functions, operation and procedures of the panel are detailed in the Children in Care guidelines published by the Directorate. The guidelines state that the panel is to screen placement referrals, facilitate/recommend additional funding, monitor referrals and identify services and resources needed for children.

Unfortunately, the operation of the panel is a source of some controversy. Workers indicate that the panel is very inconsistent and unpredictable. A number of workers expressed the view that children who have very high needs, but have not suffered repeated placement breakdown in lower level facilities, are often rejected for level IV. The feeling of these workers is that a child has to be further damaged by the system before he/she will receive the level of care needed.

On the other hand members of the panel expressed the concern that the referrals and assessments by workers do not provide sufficient information to properly assess the needs of children. In the end, the effectiveness of the panel is questionable.

Some standardization and co-ordination of placements must occur. A solution would be to have the Secure

Admissions Placement Panel screen all placement referrals, as is done in some other jurisdictions. This ignores the fundamental issues of the need to increase and standardize the training of agency workers and supervisors and to ensure Standards are followed by agencies, and develop better resources for assessment.

2. Funding Issues

There are times when children are referred or accepted for placement as a result of funding or financial reasons. This is not a proper consideration.

Many children do not need the structure of a staffed facility and are best served in a foster setting. Foster placements are funded by agencies directly, whereas residential care is funded through the Directorate. Agencies currently face enormous financial pressure. Workers acknowledge that occasionally the fact the placement will not have to be paid directly by the agency is a consideration when deciding that a child should be placed in residential care.

Residential care facilities also accept placements for financial reasons. Facilities are funded on a per diem basis. As a result, if a bed is empty the facility does not receive any income (except where the child is AWOL for fewer

than 10 days). Facilities are equally constrained by financial considerations and cannot afford to have empty beds. The Review Team was repeatedly told of instances where children were refused for placement but later accepted by a facility because a bed became available and no other more suitable child was immediately available.

Group homes are under added pressure because they do not receive a grant for administrative costs. This appears to result from changes in funding arrangements over the years and is not justified. The uncertainty that occurs as a result of per diem funding makes long range planning difficult. It is essential that facilities be funded on a more predictable and equitable basis.

The Directorate has recently embarked on a program to implement service contracts with residential care facilities. One contract has been completed with Children's Home of Winnipeg and negotiations are underway with the other three treatment centres. This is an important step in addressing both equitable funding and accountability of facilities for programs and outcomes. Completion of service contracts for all residential care facilities should be a priority.

It is recommended that:

The Department enter into service contracts with all treatment centres by March 31, 1993.

The Department enter into service contracts with all residential care facilities by March 31, 1994.

The Department develop funding formulas to ensure that all residential care facilities are funded for administrative expenses.

B. TREATMENT RESOURCES

It is not unusual for residential care facilities to be unable to achieve any results with a child. As with most of the issues discussed in this section, this happens for a number of reasons.

A significant issue is the lack of clinical support and programs available to children who are in residential care. One of the anomalies in the system is that children who are placed in group homes operated by treatment centres have access to clinical staff and receive individual counselling. Other group homes are not funded for clinical support. The number of programs that are otherwise available to children in residential care is minimal. This must be addressed. It is also critical that families be involved in a child's treatment. Often children in level II or III facilities in particular, return to their families after relatively short term placements. Usually work must be done with a child's family to address the reasons that caused the

child to have to be removed in the first place. So often children return home to exactly the same situation, and end up back in care after a short period of time. This is very destructive to a child.

There is also a need for more specialized resources. A good example of this is the situation with sexual offenders. Routinely, children who are known to have engaged in sexual offending behaviour are placed with victims of sexual abuse. Some facilities estimate that as many as 60% of their residents are known to have engaged in sexually offending behaviour. Placement resources exclusively for sexual offenders in Manitoba consists of one 4 bed unit for males age 13 - 17. There are no resources for female sexual offenders.

Placing offenders with victims creates significant risks. Currently, the only available safeguard is close supervision. Inadequate staffing levels in residential care compounds the risk. Bedtime and mornings are recognized as high risk periods for children who have been abused and staffing levels are usually higher at those times. After 11:00 p.m. there is usually only one staff (often the least experienced staff) on duty in an 8 bed unit. While it is intended that children are sleeping at that time, if they are not, the risks can be substantial.

Added to this is the fact that a child who is being victimized by another child in a facility is not likely to disclose until one or the other is no longer there. Children who have had this experience have substantial fear of reprisal. Rarely do staff learn until after the fact that such situations have occurred.

Working with offenders requires specialized training and considerable support, especially if the sexual offending is only one part of a child's treatment needs. More resources are needed to adequately care for children who are sexual offenders.

Violent behaviour, gang or cult involvement are also behaviors that create risks for other children. Intense therapy and close supervision is required in both instances. Children with these types of behaviors often do not receive adequate treatment in residential care. Few youth care workers are skilled in working with children involved in cults and gangs. Many staff interviewed indicate they are afraid of them. Most facilities will not accept such children. Unfortunately, it often happens that it is after the child has been placed that the facility learns of these behaviors.

There are inadequate mental health resources for children in Manitoba. As a result, children that should properly be in mental health facilities sometimes end up in residential care.

The lack of resources outside of residential care is also a matter of concern. Repeatedly the view was expressed to the Review Team that by the time children come into the residential care system at the age of 12, many are so badly damaged that there is little the facilities can do to help them. There is an overwhelming need for better resources for young children. There is no question that the earlier that intervention takes place, the greater the chances a child will be able to overcome abuse or neglect.

At the same time, resources for older adolescents are also inadequate. Many examples were cited of children who, at the age of 16 or 17, no longer required the structure of residential care but were also not ready to live on their own. These children need the support of an independent living or proctor program. Unfortunately such resources are insufficient. As a result, children often have to remain in a residential care facility. Typically, they are disruptive, resistant to intervention and create control problems. They are AWOL frequently. It is important that the system develop

resources for these children to allow them to make the transition into independence.

There is also a lack of co-ordination of existing treatment programs and resources. Agencies, treatment centres, individual therapists and counsellors, and other organizations often develop and offer programs in isolation. This is not an effective use of resources.

It is also essential that a central directory or registry be established to provide information concerning available treatment and program resources. Much time is often wasted searching for programs for children.

C. **STAFFING LEVELS**

Frequently staff do not have enough time for the children in their care and are able to do little more than maintain some semblance of order. Controlling rather than changing behaviors is all that can be accomplished.

Developing trusting relationships with children is essential to help them heal and to make them feel safe enough to disclose. Commitment, skill, and time for individual attention are all necessary to achieve this goal. This is difficult to achieve given the complex needs of many children in residential care, and existing staffing levels.

Currently, the only way a facility can enhance staffing levels is through additional care funding from the Directorate. Additional staff is approved for an individual child if it can be demonstrated that a child is sufficiently at risk to require a one-on-one worker. A maximum of 60 hours per week is permitted per facility.

It is questionable whether additional care funding is an effective use of resources. The approval for additional care is often slow and funding is both child and facility specific. Funding will not be granted retroactively while the decision is being made. If the child moves to another facility, no funding is available for a minimum of two weeks. Further, often the need for additional staff is not "child specific". Rather it may be a combination of personalities and behaviors of the children in a facility that results in disruption and lack of control.

A related issue is the number of residents in a facility. Some facilities have as many as 10 or 11 children per unit. The combined effect of behaviors and needs, regardless of staffing levels, makes it difficult for any meaningful one-on-one interaction to occur.

D. RURAL AND NORTHERN RESOURCES

Lack of placement resources in northern and rural Manitoba results in many children being placed in Winnipeg. The effect of being hundreds of miles away from home, in a large urban centre, and in a setting dramatically different from any a child has previously experienced can be devastating. It is essential that additional rural resources be developed, particularly in the North.

E. THE NEED FOR PLACEMENT RESOURCES

The Child and Family Services Act requires that the Director ensure the development of appropriate placement resources for children. It is questionable whether this obligation is currently being met.

It is difficult to determine which of the many issues identified above are cause and which are effects of inadequate placement resources. Most are both. Lack of adequate funding and lack of accountability are underlying factors in most every situation.

The growth in demand for services that has occurred as a result of recognition of child abuse as a social problem of great magnitude has never been acknowledged. The impact of violence and inter-generational abuse and dysfunction has created complex problems which have put enormous pressure on the system.

Typically changes in child welfare have been piecemeal and in reaction to a specific problem, and often at a time of crisis. Long term planning does not usually occur.

It is essential that changes occur on a rational and planned basis and with the input and participation of those who are involved in the system.

It is recommended that:

The Department of Family Services develop a three year plan to address the need for:

- additional specialized placements including assessment resources, placements for sexual offenders and other high risk children;
- increased staffing levels and clinical support for all residential care facilities;
- resources in rural and northern Manitoba;
- culturally and linguistically appropriate resources for Aboriginal children
- additional resources for children under twelve;
- additional resources for older adolescents.
- co-ordination of treatment programs and resources in the Province.

The Department of Family Services ensure that adequate training of agency workers and supervisors occur.

The Directorate establish a central directory of all treatment programs/resources available throughout the Province.

F. ABORIGINAL CHILDREN

One of the principles of The Child and Family Services Act is that "families are entitled to services which respect their cultural and linguistic heritage". In the case of Aboriginal children in residential care, this does not usually happen.

The report of the Aboriginal Justice Inquiry (AJI) identified numerous issues related to the inability of the child welfare and justice systems to address the needs of Aboriginal children. Specifically, the AJI report identified the need to develop culturally appropriate services and resources and to ensure cross-cultural training of staff. The AJI report recommended that the proportion of Aboriginal workers in any facility be equal to the proportion of Aboriginal children in their care or custody. These recommendations are strongly supported.

The children's residential care system is a prime example of the concerns raised by the AJI report. The system has not been successful in finding creative ways to meet the unique needs of Aboriginal children in care.

It has been difficult for Aboriginal people to participate in the residential care system. There has never

been a forum for dialogue between the Aboriginal community and residential care.

The time is right for the residential care system and Aboriginal service organizations to address ways for residential care to better serve Aboriginal children. This will only happen if the Aboriginal community is a key participant in making such changes. Recently there has been a number of collaborative efforts between Aboriginal service organizations and various government agencies. For example, the City of Winnipeg and the Ma Mawi Wi Chi Itata Centre have established a Victims Assistance Program where an Aboriginal social worker assists City Police in investigating crimes involving Aboriginal victims. Ma Mawi Wi Chi Itata Centre also operates a bail supervision program for Aboriginal young offenders. In addition, Child and Family Services of Winnipeg has entered into an arrangement with the Native Womens' Transition Centre to support its Safehouse.

A forum must be established to allow for dialogue between the Aboriginal community and residential care. It is important that discussions include a wide range of representation from Aboriginal service organizations. One way to ensure this is for an advocacy group such as the Aboriginal Women's Unity Coalition to play a leadership role. Child and Family Service agencies, residential care and Young Offen-

der's facilities, probation services and former residents of facilities should also be involved.

It is recommended that:

The Departments of Family Service and Justice jointly sponsor a workshop to discuss ways in which residential care and Young Offender's facilities can provide services to better meet the cultural and linguistic needs of Aboriginal children.

An advocacy group such as the Aboriginal Women's Unity Coalition be asked to play a leadership role in organizing and conducting the workshop.

G. LEADERSHIP ISSUES

It is essential to the effective functioning of the residential care system that the various components be supportive of each other and work in a collaborative and co-operative manner. Unfortunately, the system is highly politicized. Relationships among agencies, facilities, and the Directorate are often adversarial. There is neither a sense of common goal or collective responsibility. Typically when something goes wrong, the system looks for someone to blame when the culprit is often the system itself.

To be effective, facilities must be supportive, nurturing and respectful of children. They must listen to children. Those who work in the system must also value, respect, and listen to each other. It is ironic that the system has not been able to provide the same type of supports

to those working in the system as it expects facilities to provide for children. Confusion over roles, lack of accountability, chronic underfunding and inefficiency contribute greatly to this situation.

There is a deeper and more troubling problem. Many senior members of the child welfare community express concern over the lack of direction the system receives. The system seems to have lost sight of the fact that is exists to protect children.

More is known today than ever before concerning child abuse and treating its victims. There are many skilled and dedicated people who individually, or in small groups, have created "islands of excellence" within the system. Despite this, the system as a whole is stagnate. Creativity is stifled, innovation is discouraged, and the justification for too many failings is lack of resources. At a time when child welfare must find ways to be more effective, it appears complacent in its decay. For any change to be meaningful, it is essential that this fundamental issue be addressed.

RECOMMENDATIONS

1. Consideration be given to changing the definition of "physical abuse" in the Child and Family Services Act to use the term "physical harm" instead of physical injury.

2. The definition of emotional abuse in The Child and Family Services Act be replaced with a new definition which uses the phrase "emotional harm".

   "Emotional harm" be defined further in the Act to include observable behaviors similar to the provisions in the Alberta, Nova Scotia and Ontario statutes.

3. The Child and Family Services Act be amended to include specific reference to past abuse within the mandatory reporting requirements.

   The Guidelines be revised to be consistent with the Act.

4. The Child and Family Services Act be amended to include a specific definition of third party assault and the Act clearly state that third party assault is subject to the mandatory reporting provisions.

5. The Child and Family Services Act be amended to set a maximum penalty for failing to report as required in section 18; and, that the maximum penalties be, at minimum, a fine of $2,000.00, a one year prison term, or both.

6. The Child and Family Services Act be amended to provide that where a person violates the mandatory reporting provisions whose occupation, profession or official duties involves the care, custody, control or charge of, or unsupervised access to children be subject to a maximum penalty of a fine of $5,000.00, a one year prison term, or both.

7. Failure to report as required in section 18 of The Child and Family Services Act be designated as a continuous offence. or,

The Act be amended to provide that a prosecution for failure to report as required in section 18 may not be commenced later than one year after it came to the knowledge of an agency or the Director.

8. Section 18.2(1) of The Child and Family Services Act be amended to require the Director to report to the relevant professional society, association or regulatory body when the Director has reasonable grounds to believe that a person has violated section 18 and that person's occupation, profession or official duties involves the care, custody, control or charge of or allows unsupervised access to children.

9. The Child and Family Services Act be amended to provide a maximum penalty for interfering or harassing an informant; and, that the maximum penalties be no more than a fine of $2,000.00, a one year prison term, or both.

The Child and Family Services Act be amended to provide that a prosecution for interfering or harassing an informant cannot be commenced later than two years after knowledge of the offence came to the attention of an agency or the Director.

10. A section be added to The Child and Family Services Act to stipulate that no person shall interfere with, impede or obstruct or attempt to interfere with, impede or obstruct the reporting or investigation of a child in need of protection.

A section be added to the Act which states that anyone found to violate the clause recommended above is guilty of an offence and liable to a fine of up to $2,000.00, a one year prison term, or both.

11. The Child and Family Services Act be amended to impose higher penalties for a person found to have interfered or harassed an informant when that person's professional, official or employment duties involves the care, custody, control or charge of a child or permits unsupervised access to children.

Maximum penalties for these offences be set at a fine of $5,000.00, a one year prison term or both.

12. Section 18.2(1) of The Child and Family Services Act be amended to require the Director to report to the relevant professional society, association or regulatory body and to the person's place of employment when the Director has reasonable grounds to believe that a person has committed an interference or obstruction type offence.

13. The Child and Family Services Act be amended to provide that any person who falsely and maliciously report information to an agency that a child is in need of protection and is guilty of an offence and is liable to a maximum fine of $2,000.00, a one year prison term, or both.

14. All Young Offenders facilities be licensed pursuant to section 8(1) of The Child and Family Services Act.

The Minister of Family Services delegate licensing authority to the Provincial Director of The Young Offenders Act similar to what is done for open custody homes.

The operational reviews incorporate relevant Child and Family Services Standards for children's residential care facilities.

The Child and Family Services Standards related to services for young offenders be amended to provide a more comprehensive protocol for reporting and investigating allegations of abuse in young offender's facilities.

15. St. Amant Centre be licensed as a children's residential care facility pursuant to section 8(1) of the Act.

The existing standards be amended to include special services for disabled children in care.

The Department of Family Services clearly articulate that standards for programming at St. Amant Centre are to be monitored under the jurisdiction of the Director of Child and Family Services.

16. An immediate management review of Seven Oaks be conducted.

A management committee be appointed forthwith to oversee the operation of Seven Oaks. This committee should be given the usual powers and authorities of a Board of Directors.

Seven Oaks be licenced pursuant to Section 8(1) of the Act.

The Department work in conjunction with the Manitoba Government Employee's Association to have employees moved to the social services component of the Collective Agreement.

The Department work with the Department of Health to ensure appropriate placement resources for children needing psychiatric services.

The Department develop a three year plan to close Seven Oaks, and replace it with alternative receiving resources.

17. The Director of Child and Family Services be the designated licensing authority for children's residential care facilities.

Regulations be developed pursuant to The Child and Family Services Act setting out the licensing criteria for children's residential care facilities.

One set of standards be developed for children's residential care facilities.

The standards contain a separate section on reporting where a child may be in need of protection.

The standards include a uniform policy for reporting to be utilized by all children's residential care facilities.

The uniform reporting policy:

- clearly state the first-disclosure recipient is responsible for reporting to an agency;

- encourage consultation with experts external to the facility such as the police, an agency or the Directorate;

- where the alleged offender is a staff member, require steps to be taken to ensure the staff member is to have no contact with children in the facility until an investigation is completed, and that the Board of the facility be notified to the report;

- where the alleged offender is in a management position, or there is reason to believe management had prior unreported knowledge of the incident, that management not be notified of the report and, the Board of the facility be notified after a report has been made to the agency;

- all staff be provided with a copy of the uniform policy and be required to sign an acknowledgement that they have read and understood the policy.

- facilities provide the Directorate with a copy of all signed acknowledgements from staff.

18. The Department of Justice, in conjunction with the Department of Family Services, review the internal policies for reporting suspected child abuse at the youth correctional facilities to ensure consistency with the definition of a child in need of protection, and mandatory reporting in The Child and Family Services Act.

All youth correctional facilities adopt the Uniform Reporting Policy contained in the Child and Family Service Standards.

19. Regulations be passed requiring all residential care facilities to instruct staff in the reporting requirements of the Child and Family Services Act at the time of employment and on an annual basis thereafter.

20. A central team be established to conduct investigations of allegations of abuse in children's residential care facilities.

The team be assigned to the office of The Children's Advocate.

A protocol for investigations be developed and circulated to all residential care facilities.

The Central Investigation Team develop a system to categorize conclusions of investigations. Any conclusions address concerns related to standards, appropriateness of behavior and job performance.

All conclusions be communicated in writing to the facility, the person accused, the agency, the child and the Directorate.

21. The Department establish a fund to cover the salary of any employee suspended as a result of an allegation of abuse pending the conclusion of an investigation.

22. An employee assistance program be made available to all residential care facilities and be funded by the Department of Family Services.

23. The Department of Family Services implement a funding formula for residential care facilities to allow for parity with Provincial facilities.

24. The Minister of Family Services establish a Curriculum Development Committee which includes representation from residential care facilities and youth care workers.

25. The Curriculum Development Committee work in conjunction with the Department of Education, community colleges and other educational institutions to develop an appropriate educational training program for youth care workers.

26. Regulations be passed pursuant to The Child and Family Services Act, to set classification levels for youth care workers and minimum qualifications for each level.

Such regulations specify time periods within which all staff in facilities are to be classified, similar to those contained in The Community Child Day Care Standards Act.

The Curriculum Development Committee develop youth care competencies to establish a program of competency based assessments.

The regulations set forth the time periods during which all staff are to meet the minimum qualifications, and allow upgrading and competency based assessments to occur.

The Directorate establish a registry for youth care workers to monitor the progress of the classification process.

27. All residential care facilities be required to provide the Directorate with a list of all staff and thereafter notify the Directorate of any changes in staff.

28. The Curriculum Development Committee identify and develop a series of core courses for youth care workers, and such courses be immediately available for staff in residential care facilities.

The Directorate establish a fund to cover the costs of delivering these courses and replacement of staff.

29. Training in Aboriginal cultural and linguistic issues be included in the core courses developed by the Curriculum Development Committee.

30. A comprehensive Code of Conduct be developed for all residential care facilities.

31. The Curriculum Development Committee develop a set of core courses for supervisory staff in residential care facilities.

32. Non-violent crisis intervention and self awareness training be included in the core courses developed by the Curriculum Development Committee.

33. The Department of Family Services make available project funding to develop a safe practice manual for youth care workers.

34. All residential care and youth corrections facilities include as part of orientation for new staff, safe practice guidelines and procedures for investigating allegations of abuse against staff.

35. A standardized screening procedure for all residential care and youth corrections facilities be developed.

Any persons responsible for hiring in a residential care or youth corrections facility be trained in the use and implementation of such procedures.

All residential care and youth corrections facilities employ thorough reference checks in screening job applicants.

36. Amendments be made to The Child and Family Services Act to include third party assaults in the definition of abuse for purposes of the Child Abuse Registry; or

Section 19(4) of the Child and Family Services Act be amended to include persons convicted of criminal offences against children.

37. The Child and Family Services Act be amended to provide that agencies or the Director be notified when a person is charged with an offence based on alleged acts or omissions by that person in relation to a child.

38. The Department of Family Services and the Department of Justice develop and implement a process whereby relevant convictions are automatically referred to the Child Abuse Registry.

39. The Child and Family Services Standards require children be informed of their rights and entitlements prior to, or upon entering a residential care facility.

The Child and Family Services Standards require children be re-informed of their rights and entitlements at least every six months while in care.

The Child and Family Services Standards require all residential care facilities to have a grievance procedure which fully explains all avenues of appeal available to children under the Act.

All residential care facilities be required to display, in a conspicuous location, children's rights and entitlements, employee codes of conduct, and grievance or complaint procedures.

The Child and Family Services Standards require that, upon placement, the child be advised of the grievance and complaint procedure both internal and external to the facility.

The Child and Family Services Standards explicitly require that parents and guardians be informed of their rights and the rights of their children.

40. Youth correctional facilities be required to inform children in custody of their rights under The Young Offenders Act and their rights specific to the facility in which they are placed while in custody.

Youth correctional facilities be required to inform the child's parents or guardians of their child's rights as well as their parental/guardian rights related to their child being in custody.

Youth correctional facilities be required to inform children of the grievance/complaint procedures applicable to the facility within which they are placed as well as those avenues available to them which are external to the facility in which they are placed.

Youth correctional facilities be required to post grievance/complaint procedures, employee codes of conduct, and children's rights while in custody in conspicuous locations throughout.

A child in custody be re-informed of his or her rights at regular intervals while in custody.

41. The Department of Family Services and the Department of Justice review all applicable legislation, regulations standards and guidelines with respect to children in care or custody in light of the provisions contained in the U.N. Convention on the Rights of Child to ensure consistency.

42. The Child and Family Services Act, Regulations and Standards be reviewed to ensure consistency with the Canadian Charter of Rights and Freedoms.

Reference be made to the Canadian Charter of Rights and Freedoms with respect to children in care under The Child and Family Services Act, Regulations and Standards.

43. Regulations be passed pursuant to The Child and Family Services Act establishing criteria for the admission, length of stay and review of placement in locked facilities; and the approval and use of a locked room within residential facilities.

Standards be developed establishing criteria for the use of confinement to an unlocked room as a disciplinary method and that such standards require the child's worker to be notified each time an unlocked room is used for confinement.

44. The Children's Advocate report directly to the Legislature as recommended in the report of the Aboriginal Justice Inquiry.

The mandate of the Children's Advocate include individual and systemic advocacy.

An information package on the Children's Advocate be given and explained to children when they come into care.

All residential care and young offenders facilities be required to post, in a conspicuous location, an information sheet on the Children's Advocate.

The information package and information sheet use language and be designed in a manner that is appropriate for children.

45. Regulations be passed pursuant to The Child and Family Service Act requiring that all residential care facilities be operated by an incorporated organization with an elected Board of Directors, or in the case of social, charitable or community service agencies, a Management Committee consisting of a minimum of five persons, none of whom are members of the immediate family of an employee, and not more than 20% of whom are employees of the facility.

The Directorate publish an orientation handbook for Boards of Directors and Management Committees of residential care facilities.

The Directorate sponsor an annual orientation meeting for all persons who are serving as directors or members of management committees of residential care facilities.

All residential care facilities ensure that line staff are represented on the Board or Management Committee.

All residential care facilities establish a Personnel Committee whose functions include meeting with line employees at least once annually.

The Child and Family Services Standards be amended to require that all residential care facilities have a grievance procedure which requires a copy or notice of any grievance filed by a child be provided to the Board of Directors/Management Committee.

46. Agencies ensure that workers receive training in standards related to residential care facilities.

The Directorate take steps to ensure that all agencies are complying with Child and Family Service Standards.

47. Three staff be assigned to the Directorate as Residential Care Co-ordinators with the responsibility for conducting licensing and standards reviews similar to what is done in Day Care.

Residential Care Co-ordinators each be assigned responsibilities for licensing and assessing standards in a set number of facilities.

Procedures for conducting the reviews be developed and provided to residential care providers which clearly outline the purpose of the reviews, the process to be followed, and the role of the Directorate and facility staff.

A report be produced at the end of each review that is shared with the facility.

The Directorate prepare an annual report on all licensing and standards reviews done at residential care facilities.

A copy of the annual report be given to all children's residential care facilities, mandated agencies, regional offices, the Children's Advocate, the Chief Medical Examiner and the Ombudsman.

48. The Department enter into service contracts with all treatment centres by March 31, 1993.

The Department enter into service contracts with all residential care facilities by March 31, 1994.

The Department develop funding formulas to ensure that all residential care facilities are funded for administrative expenses.

49. The Department of Family Services develop a three year plan to address the need for:

- additional specialized placements including assessment resources, placements for sexual offenders and other high risk children

- staffing levels and clinical support for all residential care facilities;

- resources in rural and northern Manitoba;

- culturally and linguistically appropriate resources for Aboriginal children;

- additional resources for children under twelve;

- additional resources for older adolescents.

The Department of Family Services ensure that adequate training of agency workers and supervisors occur.

The Directorate establish a central directory of all treatment programs/resources available throughout the Province.

50. The Departments of Family Service and Justice jointly sponsor a workshop to discuss ways in which residential care and Young Offender's facilities can provide services to better meet the cultural and linguistic needs of Aboriginal children.

An advocacy group such as the Aboriginal Women's Unity Coalition be asked to play a leadership role in organizing and conducting the workshop.

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